

6768

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
17 TOWN <i>Takoma Park</i>	14 da-	TOWN <i>Takoma Park md 17</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
17 Penic one -		17 Penic one -	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH:	
(Type or Print) <i>Barry Lee Ackerman</i>		<i>July 29 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>m.</i>	<i>wh.</i>		<i>Mar 15, 1955</i>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
yrs. <i>4</i>		Months <i>11</i> Days <i>11</i> Hours <i></i> Min. <i></i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
			<i>Takoma Park, md -</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Orva L Ackerman</i>		<i>Edith Griffiths</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
		<i>Orva L Ackerman - 17 Penic one T.P.</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
752x IMMEDIATE CAUSE (A) DUE TO			
ANTECEDENT CAUSE (S) (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <i>Hydrocephalus.</i> <i>Birth abnormality.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Mar 15, 1955</i> , to <i>July 28, 1955</i> , that I last saw the deceased alive on <i>July 28 1955</i> , and that death occurred at <i>1:09 AM</i> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<i>Keith Stantard</i>		<i>M. D. Wash Son + Hosp.</i>	
		DATE SIGNED <i>July 29, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Transit. Burial</i>		<i>July 29, 1955</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Lambertville</i>		<i>Pa</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>J. Arthur Walters</i>		<i>254 Canoe st NW</i>	
<i>Takoma Park D.C.</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ju 5-5461

RECEIVED
AUG 2 1955
BUREAU V. S.

6796

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>Washington, D.C.</u>	
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>45 Min</u>		CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>Washington, D.C.</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>13 Jib Green, S.W.</u>			
3. NAME OF DECEASED: (First) <u>Margaret</u>		(Middle) <u>(N)</u>		(Last) <u>ACOSTAR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Malayan</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>29 July 1955</u>		9. AGE last birthday <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Atanacio ACOSTAR</u>				14. MOTHER'S MAIDEN NAME: <u>Confesor MIRANDA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Father Atanacio ACOSTAR Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>770.5 Prematurity</u>						<u>45 min</u>	
ANTECEDENT CAUSE (S) <u>(Hydrops fetalis)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hemolytic disease of undetermined type</u>							
(C) <u>Microcephaly</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 July, 19 55</u> to <u>29 July, 19 55</u> that I last saw the deceased alive on <u>29 July, 19 55</u> , and that death occurred at <u>5:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Pearson</u>				ADDRESS		DATE SIGNED	
H. A. PEARSON LTJG. MC, USN, U.S. Naval Hospital NNMC Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT OLIVET</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-29-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>		24. FUNERAL DIRECTOR <u>R. A. Humphrey Funeral Home</u>		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

2075313283

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

6797

CERTIFICATE OF DEATH

Reg. Dist. No. 512

1. PLACE OF DEATH: <u>Kensington Nursing Home</u>		USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Kensington</u>	LENGTH OF STAY (in this place) <u>7/7/55-7/22/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 KENSINGTON GARDENS NURSING HOME</u>		STREET ADDRESS (If rural give location) <u>4417 Bradley Lane</u>	<u>1</u>
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>G.</u> (Last) <u>ADAIR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>22</u> <u>1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Nov-4, 1880</u>
9. AGE last birthday: <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>18</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Boiler-Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Gov.</u>	11. BIRTHPLACE (State or foreign country): <u>Michigan</u>
13. FATHER'S NAME: <u>John Adair</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Wife- 4417 Bradley Lane, Chevy Ch. Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>491X</u> <u>Bronchopneumonia bilateral</u>		<u>7/15/55-7/22/55</u>	
ANTECEDENT CAUSE (S) <u></u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u></u>			
(C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility-generalized arteriosclerosis</u>			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> , to <u>July 22, 1955</u> , that I last saw the deceased alive on <u>July 21, 1955</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank A. Gray, Jr.</u>		M. D. <u>104 Chevy Chase Dr. C. Md. 7/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-28-55</u>	REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 26 1955

RECEIVED

6760

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06768
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 223-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Takoma Park</u>		TOWN <u>Chevy Chase</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium & Hospital</u>		STREET ADDRESS (If rural, give location)	<u>29 W. Irving St</u>
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print) <u>Susan</u>	<u>Alburtis</u>	<u>July</u>	<u>11</u> <u>1955</u>
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>9-14-1865</u>
		9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Summer Camp Director-Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME: <u>Edward N. Sipe</u>	14. MOTHER'S MAIDEN NAME: <u>Emma Bender</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>Hosp. Chart</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) DUE TO <u>Coronary thrombosis</u>		<u>1 hr.</u>
Antecedent cause(s) (b) DUE TO <u>Generalized arterio-sclerosis</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>7-14-55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Frank J. Broschart CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7-11-55
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7-14-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Dakhill</u>	LOCATION (City, town, or county) (State): <u>Wash. D.C.</u>
DATE REC'D BY LOCAL REG. <u>July 11-1955</u>	REGISTRAR'S SIGNATURE: <u>J. Nelson Dodd</u>	24. FUNERAL DIRECTOR: <u>Phy. Chase F. H.</u>	ADDRESS: <u>5103 W. W. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 18 1955

RECEIVED

6799

06769

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Gaithersburg</u>		<u>50A</u>		<u>Gaithersburg (rural)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Diamond Ave</u>				STREET ADDRESS (If rural, give location) <u>Rt 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jackie Andrew Arnold Jr</u>				<u>7-7-1955</u>			
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>w</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>7-7-31</u>	
				9. AGE last birthday: <u>24</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>City Work Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Laskie Arnold</u>				14. MOTHER'S MAIDEN NAME: <u>Maude Mc Mahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>fighting in Korea</u>				16. SOCIAL SECURITY No.: <u>220-285681</u>		17. INFORMANT & ADDRESS: <u>Washington Grove Md</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>Sudden death</u>
Immediate cause (a) <u>Cerebral hemorrhage</u> DUE TO							
Antecedent cause(s) (b) <u>Compound fracture of skull</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc.,) OF INJURY <u>highway</u>		21c. (City or town) (County) (State) <u>Gaithersburg Montg 15 md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-7-55 11:30 P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Driver of auto which struck right side</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschait</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-8-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 10 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lanier Oak</u>		LOCATION (City, town, or county) (State) <u>Gaithersburg md</u>	
DATE REC'D BY LOCAL REG. <u>July 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Alvin L. Goble</u>		24. FUNERAL DIRECTOR <u>Ray W. Barber</u>		ADDRESS <u>Koptonsville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

JUL 12 1955

RECEIVED

6791

CERTIFICATE OF DEATH

Reg. Dist. No. 06770
216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>7 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9109 Rockville Pike Stoneridge Convent</u>				STREET ADDRESS (If rural give location) <u>9109 Rockville Pike</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mother Victoria Avellaneda R.S.C.J.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 18, 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12-10-1872</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Religious</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Nun</u>		11. BIRTHPLACE (State or foreign country): <u>Argentina</u>		12. CITIZEN OF WHAT COUNTRY? <u>Argentina</u> ✓	
13. FATHER'S NAME: <u>Nicolas Avellaneda</u>				14. MOTHER'S MAIDEN NAME: <u>Carmen Nobrega</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Convent Records 9109 Rockville Pk., Wash. 14, DC</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>						<u>4 days</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Acute Coronary Thrombosis</u>						<u>4 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Coronary Heart disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterial Thrombosis & Left Hemiplegia (old)</u>						<u>5 years -</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14</u> , 19 <u>55</u> , to <u>July 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>55</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Phyllis J. Sigmond</u>		M.D. <u>Bethesda, Maryland.</u>		DATE SIGNED <u>7/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Eden Hall Convent</u>		LOCATION (City, town, or county) (State) <u>Torresdale, Phila. Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Francis J. Collins</u>		ADDRESS <u>3821-14th St. N.W. Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

87130018

BUREAU V. S.

III 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6799 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda, Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>4403 Elm St.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>ANDREW S. BAIN</u>	4. DATE (Month) (Day) (Year) OF DEATH: <u>July 1, 19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 13, 1892</u>
9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR: Months <u>10</u> Days <u>18</u> Hours <u></u> Min. <u></u>

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sales Representative-Chicago Co.</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Pump</u>	11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
---	--	---	--

13. FATHER'S NAME: <u>Andrew M. Bain</u>	14. MOTHER'S MAIDEN NAME: <u>Alice Davies</u>
---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY No. <u>577-05-8267</u>	17. INFORMANT & ADDRESS: <u>Leah S. Bain- Wife</u> <u>4403 Elm St, Chevy Chase, Md.</u>
--	--	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>443X</u>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(A) DUE TO <u>Uremia (UREMIC poisoning)</u>	<u>10 days</u>
	(B) DUE TO <u>Hypertensive Heart Disease</u>	<u>5 yrs</u>
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from June 30, 1955, to June 1, 1955, that I last saw the deceased alive on June 30, 1955, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	M. D. <u>8016 Georgetown Rd</u>	DATE SIGNED <u>7/2/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-5-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>

DATE REC'D BY LOCAL REGISTRAR <u>7/2/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
---	---	--	------------------------------

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 31

JUL 6 1955

RECEIVED

68 0

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>P.R. Geo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Bethesda Rural</u>		<u>1 da.</u>		OR TOWN <u>Glassmanor</u>		<u>16 X - 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>217 Hampton Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Baby Girl</u> <u>BALAWAG</u>				<u>July 2 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>Malayan</u>		<u>SINGLE</u>		<u>7-1-55</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
		<u>1</u>		<u>1</u>		<u>1</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>NONE</u>				<u>NONE</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Pedro Baccay BALAWAG</u>				<u>Socorro ZIPAGAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>-</u>		Father: <u>Pedro V. BALAWAG 217 Hampton St. Glassmanor, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
<u>763.0 Suspected Interstitial</u>							
ANTECEDENT CAUSE (S)							
<u>Pneumonia</u>						<u>10 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Term I infant born by Caesarian section</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 July</u> , 19 <u>55</u> , to <u>2 July</u> , 19 <u>55</u> that I last saw the deceased alive on <u>2 July</u> , 19 <u>55</u> , and that death occurred at <u>12:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. S. Mathews, M.D.</u>				ADDRESS <u>DATE SIGNED</u>			
<u>W.S. MATHEWS, LCDR MC USN U.S. Naval Hospital, NMMC, Bethesda, Md.</u>				<u>7-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6 July 55</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-3-55</u>		<u>Mary E. Carrelly</u>		<u>Robert A. MAPPINGLY 131 11th St. Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2075386395

BUREAU V. S.

APR 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06773

6801

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>4 yrs. aprx.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9401 Woodland Drive</u>		STREET ADDRESS (If rural give location) <u>9401 Woodland Drive</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Turner Barber</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 28</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 13, 1904</u>
9. AGE last birthday: <u>51</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman--R.P. Andrews Paper Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Forest Glen, Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William S. Barber</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-9502</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Vera N. Barber, 9401 Woodland Dr., SS., Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>5 minutes</u>
ANTECEDENT CAUSE (S) (B) <u>Arterio sclerosis</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M) (P) (A) (N)		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 10, 1950</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 28, 1955</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>George B. Patrick</u>		DATE SIGNED <u>7-28-55</u>	
ADDRESS <u>8700 Colesville Rd. Silver Spring, Md.</u>		M.D. <u>7-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-31-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

BUREAU V. S.

MAR 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6802 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06774

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u> Rural		4 mos 17 days		TOWN <u>Alexandria</u>		83x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>334 N. Columbus Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Gust (N) BARKES				DEATH: July 2 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 5-2-92	
				9. AGE last birthday: 63 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook				10B. KIND OF BUSINESS OR INDUSTRY: Restaurant		11. BIRTHPLACE (State or foreign country): Greece	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME: Jimmy BARKES				14. MOTHER'S MAIDEN NAME: Lena (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT & ADDRESS: Friend Mrs. Billie FREEMAN				334 N. Columbus Street, Alexandria, Va.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Metastases of Carcinoma</u>						6 mos.	
ANTECEDENT CAUSE (S) DUE TO <u>Squamous Cell Ca Esophagus + Pancreas</u>						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 15 Feb., 1955, to 2 July, 1955, that I last saw the deceased alive on 2 July, 1955, and that death occurred at 9:08 PM, from the causes and on the date stated above.							
S. D. BOND CDR MC USN U. S. Naval Hospital P. NMHC Bethesda, Maryland				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-6-55		Arlington National		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-3-55		Mary E. Casselley		Chambers Funeral Home		517 11th St. Washington, D.C.	

BUREAU V. SI

6 1955

RECEIVED

6829

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06775

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Olney	COUNTY	Montgomery
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Burtonsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sharon Nursing Home	STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First)	(Middle)	(Last)	
Nathan	Francis	Beall, Jr.	July 26 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Widowed	8/26/79
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
75 yrs.		Maryland	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Nathan Francis Beall, Sr.		Marceline Burton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		Hospital Record	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		422.2	
IMMEDIATE CAUSE		(A) Congestive heart failure, chronic	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) Chronic myocarditis	
		DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan., 1952, to July, 1955, that I last saw the deceased alive on 9/25, 1955, and that death occurred at 5:45PM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
M.D. Immedy Spurgis, M.D.		9/29/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		July 29-55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Union Cemetery		Burtonsville Md	
24. FUNERAL DIRECTOR		ADDRESS	
7-28-55		Walter Ronaldson Samuel M.D.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1955
BUREAU V. S.

684

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>56 Silver Spring</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 2714 Arvin Street</u>				STREET ADDRESS (If rural give location) <u>2714 Arvin St.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Karen Lee Bean</u>				<u>July 7 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5/28/1949</u>	9. AGE last birthday: <u>6</u> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>Jackson Bryan Bean</u>				14. MOTHER'S MAIDEN NAME: <u>Norberta Bramell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Father - 2714 Arvin St</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Arrest</u>						<u>not once</u>	
ANTECEDENT CAUSE (S): (B) <u>Congenital Heart block</u>						<u>life</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart disease</u>						<u>life</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Herpangina</u>						<u>3 days</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Spring, 1952</u> to <u>July 7, 1955</u> ; that I last saw the deceased alive on <u>July 5, 1955</u> , and that death occurred at <u>5:30 PM.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry J. Lee M.D.</u>		ADDRESS <u>M.D. 927 Pershing Dr. Silver Spring Md</u>		DATE SIGNED <u>7/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-11-55</u>		REGISTRAR'S SIGNATURE <u>Frances Toller</u>		24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. L.

JUL 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Montgomery</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>Rt 2, Hollywood</u>	
3. NAME OF DECEASED: (Type or Print) <u>Walter K. Bennett</u>		4. DATE OF DEATH <u>July 8</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>July 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
13. FATHER'S NAME: <u>W. E. Bennett</u>		14. MOTHER'S MAIDEN NAME: <u>OT. Copenhaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Charles K. Bennett (same address)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause (a) <u>Congestive Heart failure</u>		<u>several days</u>	
Antecedent cause(s) (b) <u>Atherosclerosis, severe, coronary</u>		<u>yes?</u>	
DUE TO (c) <u>hypertension</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia, bilateral</u>		<u>yes</u>	
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John W. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8 July 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>July 12, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Fort Myer, Va.</u>	LOCATION (City, town or county) (State)
DATE REC'D BY LOCAL REG. <u>7-11-55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u>	ADDRESS <u>Silver Spring Md.</u>

BUREAU V. S.

1955

ED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06778

6770

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park,</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Wash. San. & hosp.</u>				STREET ADDRESS (If rural give location) <u>71812 Piney Branch rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Berlin Brathway Biller</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7-21, 1955</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>9-12-21</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Esso</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Lewis F. Biller</u>				14. MOTHER'S MAIDEN NAME: <u>Annie E. Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>?</u>		17. INFORMANT & ADDRESS: <u>wife - Same</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Hepatitis</u>						<u>4 weeks</u>	
ANTECEDENT CAUSE (B) <u>Laennee Cirrhosis</u>						<u>1 yr approx</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 17, 1955</u> to <u>July 21, 1955</u> , that I last saw the deceased alive on <u>July 21, 1955</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ralph P. Patten</u>		M. D. <u>8641 Colver Rd.</u>		DATE SIGNED <u>July 21, 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>July 22, 1955</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>Mt. Jackson, Shenandoah Co., Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 22 1955</u>		REGISTRAR'S SIGNATURE <u>J. William Dodd</u>		24. FUNERAL DIRECTOR <u>Wm. C. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

RECEIVED

JUL 25 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6826
CERTIFICATE OF DEATH

06779

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Bethesda Rural</u>		<u>20 Hr 28 Min</u>		<u>Washington, D.C. 47 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>20 Logan Circle N.W.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Day) (Year)	
<u>Baby</u>		<u>Girl</u>		<u>July 14</u>		<u>1955</u>	
5. SEX:		6. COLOR OR RACE:		8. DATE OF BIRTH:		9. AGE last birthday	
<u>Female</u>		<u>Negroid</u>		<u>Single</u>		<u>7-13-55</u>	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)				IF UNDER 1 YEAR Months Days Hours Min.	
						<u>20 28</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Bethesda, Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry Robert BLACKWELL</u>				<u>Shirley Romaine HOLDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Father Henry Robert BLACKWELL</u>	
						<u>Same as above</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
762.5 IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
A. Pulmonary Hypertension							
B. Membrane Disease							
C. Prematurity at 4 Mo's - Wt. 2 lbs 13 oz -							
INTERVAL BETWEEN ONSET AND DEATH							
20 hr 28'							
20 hr 28'							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While Not while at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 13 July, 1955, to 14 July, 1955, that I last saw the deceased alive on 14 July, 1955, and that death occurred at 6:00 PM from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>W. S. Matthews, M.D.</u>				<u>U.S. Naval Hospital, NMMC, Bethesda, Maryland</u>		<u>7-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>7-17-55</u>		<u>Lottsburg Cemetery Northumbland County, Lottsburg, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>7-14-55</u>				<u>Mary E. Parrelly</u>		<u>Henry S. WASHINGTON, 467 N. ST. N.W. Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

2075181321

BUREAU V. B.

JUL 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0R700

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Mont</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Mont.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>X</u> TOWN <u>Bethesda</u>	<u>1 hour</u>	<u>Silver Spring 56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>74 Suburban</u>	<u>4408 Gridley Rd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Ellen Ann Blanchard</u>		<u>July 13 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Sept. 3, 1886</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>68</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>		<u>Own Home</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Lancaster, England</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John B. Butterworth</u>		<u>Elizabeth Ann Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Elmer F. Blanchard, Silver Spring, Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		<u>1 hour</u>	
ANTECEDENT CAUSE (S)		<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Crown Aneurysm</u>			
(B) <u>Hypertensive Heart Disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED	
		While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>7/13/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/13/55</u> , 19 <u>55</u> , and that death occurred at <u>10:45</u> P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Elmer F. Blanchard</u>		<u>7/13/55</u>	
M. D. <u>11607-Vers-Mid Rd.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Ship & burial</u>		<u>July 16, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. Ann's Cemetery</u>		<u>Cranston, Rhode Island</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>7-16-55</u>		ADDRESS	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Severin M. Thompson</u>		<u>Warner E. Pumphrey Silver Spring, Md.</u>	

BUREAU V. 8

JUL 19 1955

RECEIVED

1955

[Handwritten signature]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06781

6818

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: <u>Suburban Hospital,</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>51 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital, Bethesda, Md.</u>	STREET ADDRESS (If rural give location) <u>8150 Rockville Pike</u>		
3. NAME OF DECEASED: (Type or Print) <u>Scura Mabel Blundon</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 16, 1883</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: <u>72</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Dallas Tx. Va.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Eagleson (?)</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Finney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>X</u>	
17. INFORMANT & ADDRESS: <u>Earl A. Blundon, 9 Park Valley Rd, Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>			<u>3 days (?)</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary artery thrombosis</u>			<u>3 days (?)</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary arteriosclerosis</u>			<u>—</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>hypertension obesity</u>			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> , to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 4, 1955</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Earl A. Blundon, Jr.</u>		DATE SIGNED <u>7/4/55</u>	
M.D. <u>Dr. Chas. Dr. Ch. Dr. Ch.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>7-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) <u>Prince George Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda Md</u>	

BUREAU V. S.

JUL 8 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE Florida		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X Bethesda Rural		1 Mo 4 days		TOWN Jacksonville		48X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		U. S. Naval Hospital, NMMC, Bethesda 14, Maryland		STREET ADDRESS (If rural give location)		5145 Birkenhead Road	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Robert Dalton BLYTH				July 28 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Cauc.		Married		25 OCT 1908	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
46 yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Mariner				Mariner Retired		Colorado	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Robert (n) BLYTH				Vyrna DAVIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				Unknown		Jacksonville, Fla.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.1 IMMEDIATE CAUSE				2 yrs.			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				4 hrs.			
Shock, postoperative							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
37-28-55		Splanomegaly, extreme.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 25 July, 1955 , to 28 July, 1955 that I last saw the deceased alive on 28 July, 1955 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
SIGNATURE M. L. GERBER				ADDRESS U.S. Naval Hospital, NMMC, Bethesda, Maryland		DATE SIGNED 7-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		29 JULY 1955		Ceder Hill		Suitland, Prince Georges Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-28-55		Gary E. Savelly		R. A. Pumphrey Funeral Home		5557 Wisconsin Avenue, Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06783

8,13: 6810
184 8-3-55L

Items 2, 5, 13 Film 184 8-4-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED: Cumberland			
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Pa.</u> COUNTY <u>Harris</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Camp Hill</u>		75-X-13	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bedford</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>2907 Chestnut St.</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mrs. Alice Bohn</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 18 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>4/15/1869</u>	
9. AGE last birthday: <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Mln.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>							
13. FATHER'S NAME: <u>JAMES W. Armstrong</u>				14. MOTHER'S MAIDEN NAME: <u>Infield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Mary P. Lee, 10605 Wheatley St, Kensington, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Senile Cerebral</u>						<u>acute</u>	
ANTECEDENT CAUSE (S) <u>Hypertension</u>						<u>yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>						<u>yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/13/55</u> , 19 <u>55</u> , to <u>7/15/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/15/55</u> , 19 <u>55</u> , and that death occurred at <u>11: A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>1118/55</u>		DATE SIGNED <u>7/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>7/18/55</u>		<u>Cedar Hill Crematory</u>		<u>Suitland VI.D.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <u>N.W.</u>	
<u>7-20-55</u>		<u>Bessie M. Thompson</u>		<u>VI VI Chambers</u>		<u>1400 CHAPIN ST</u>	

BUREAU V. I.

JUL 25 1955

RECEIVED

Colonel W. H. Greenleaf, 2nd and

4/10/55

Colonel W. H. Greenleaf

6811

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		3 hr 30 min		TOWN <u>Bethesda Rural</u> 47X3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>U. S. Naval Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Baby Girl BREEDLOVE</u>				OF DEATH: <u>July 4 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>Negroid</u>	<u>Single</u>	<u>7-4-55</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William BREEDLOVE</u>				<u>Iola Patricia SANDERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS:			
<u>No</u>			<u>None</u>	<u>Mother Iola P. BREEDLOVE</u> <u>4907 7th Street, N.W., Wash., D.C.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prematurity at 16 weeks</u>						<u>3 hrs 33 min</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 July, 1955</u> , to <u>4 July, 1955</u> that I last saw the deceased alive on <u>4 July</u> , 1955, and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				DATE SIGNED			
<u>W. S. MATTHEWS LCDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-12-55</u>		<u>Arlington National</u>		<u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-3-55</u>		<u>Mary E. Carrelly</u>					

MARGIN RESERVED FOR BINDING

VS. A15—10-53

2075302180

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6771
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 223

Reg. Dist.

No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Lake Park D. D. A.</u>		TOWN <u>Silver Spring</u>	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Washington Sanitarium Hosp.</u>		<u>12312 Colesville Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Dora</u>	(Middle) <u>Margaret</u>	(Last) <u>Bretz</u>	(Month) <u>7</u> (Day) <u>16</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>Caucasian</u>	<u>Widow</u>	<u>3-7-26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday:	11. BIRTHPLACE (State or foreign country):
<u>Retired</u>		<u>79</u> yrs.	<u>Hamburg Germany</u>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	12. CITIZEN OF WHAT COUNTRY?	
<u>Fritz Weimmerman</u>	<u>Dorothy</u>	<u>U.S.C.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<u>No</u>	<u>-</u>	<u>Daughter Fern M. Bean - 12312 Colesville Rd.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		<u>1 1/2 hrs.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Buschack</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-17-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Ship & burial</u>	<u>July 18, 1955</u>	<u>Loveland Burial Park</u>
LOCATION (City, town, or county) (State)	<u>Loveland, Larimer Co., Colorado</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>July 18-1955</u>	<u>J. Wilson Todd</u>	<u>Warner & Humphrey 8439 E. ave S. D. Md.</u>

BUREAU V. 2

JUL 20 1955

RECEIVED

6812

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN) <u>56</u>	STATE <u>MD.</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14003 Colesville Rd.</u>	STREET ADDRESS (If rural give location) <u>631 Ritchie Ave.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Lula W. Burch</u>		<u>7 1 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W.</u>	8. DATE OF BIRTH: <u>4/26/1980</u>
9. AGE last birthday: <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Bucklestown, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>	
13. FATHER'S NAME: <u>George R. Astin</u>		14. MOTHER'S MAIDEN NAME: <u>Mary M. Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Dorothy B. Calabano</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>593X</u>		<u>5 days</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>uramin. Hypociditis</u>			
(B) <u>hypertension</u>		<u>years</u>	
(C) <u>chronic arthritis</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1/</u> , 1953, to <u>7/1/</u> , 1955, that I last saw the deceased alive on <u>6/30</u> , 1955, and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-4-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		LOCATION (City, town, or county) (State) <u>Bellville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-1-55</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u>	
24. FUNERAL DIRECTOR <u>Harner & Company</u>		ADDRESS <u>Silver Spring</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. M.

JUL 5 1955

RECEIVED

6813

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Damascus</u>		Life		TOWN <u>Damascus</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
(Type or Print) <u>Franklin Ellsworth Burdette</u>				DEATH: <u>July 10</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Widowed	Sept. 18, 1873	81 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life.		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Own Farm</u>		<u>Damascus, Md.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Nathan J. Burdette</u>				<u>Rispa Ann Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
No		--		<u>Maxwell E. Burdette, Damascus, Md.</u>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
(a) <u>Immediate cause</u>				<u>4 mos.</u>	
(b) <u>Antecedent causes (s)</u>				<u>years</u>	
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u>				<u>years</u>	
(a) <u>Pyelonephritis</u>					
(b) <u>Chronic Prostatitis</u>					
(c) <u>Benign Hypertrophy of Prostate</u>					
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis, Mod hypertension</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION			
<u>5/17/55</u>		<u>Benign Hypertrophy of Prostate</u>			
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
<u>None</u>				(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
		m.			
22. I hereby certify that I attended the deceased from <u>5/15</u> , 19 <u>55</u> , to <u>7/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/10</u> , 19 <u>55</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
<u>Beni F. Meaden</u>		<u>M.D.</u>		<u>Boyer Clinic Damascus Md.</u>	
23. BURIAL, CREMATION, REMOVA (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>July 12, 1955</u>		<u>Damascus</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>July 11/1955</u>		<u>Deella W. Burdette</u>		<u>Oliver L. Molesworth, Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI 3

JUL 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06788

6772

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF OATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
17 TOWN <u>Takoma Park</u>		<u>4 days</u>		STREET ADDRESS (If rural give location) <u>9316 Ocala St.</u> <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 14 1955</u>			
<u>JAMES MC ELFRESH BUTLER</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-26-93</u>	9. AGE last birthday: <u>62</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chauffeur - retired</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
13. FATHER'S NAME: <u>JAMES T BUTLER</u>				14. MOTHER'S MAIDEN NAME: <u>ADA MAE YOUNG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>Yes-Unavailable</u>		17. INFORMANT & ADDRESS: <u>MRS MARY YOUNG - SAME ADDRESS</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>						<u>4 days</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>8 mo</u>	
(A) <u>Cerebral Hemorrhage</u>							
(B) <u>Hypertension</u>							
(C) <u>Arteriosclerotic Cardio Vascular Disease</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec, 1954</u> to <u>July, 1955</u> , that I last saw the deceased alive on <u>July 14, 1955</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Russell B. Arnold</u>		M. O. <u>8801 Colesville Road, Silver Spring, Md.</u>		DATE SIGNED <u>July 14, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 16-1955</u>		REGISTER'S SIGNATURE <u>William Dock</u>		24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 Ca. Ave. Silver Spring, Md.</u>	

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE ACTS OF VIOLENCE COMMITTED BY THE KKK

TO THE HONORABLE CLAYTON K. KENNEDY, ATTORNEY GENERAL

FROM THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

RE: THE ACTS OF VIOLENCE COMMITTED BY THE KKK

TO THE HONORABLE CLAYTON K. KENNEDY, ATTORNEY GENERAL

FROM THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

RE: THE ACTS OF VIOLENCE COMMITTED BY THE KKK

TO THE HONORABLE CLAYTON K. KENNEDY, ATTORNEY GENERAL

FROM THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

BUREAU V. 2

MIL 18 1955

RECEIVED

6814

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06789

Reg. Dist.

No. 214

I. PLACE OF DEATH:

COUNTY Montgomery MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Silver Spring TOWN 3 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 10104 McKinney Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits write RURAL and give nearest town) Silver Spring TOWN 56

STREET ADDRESS 10,104 McKinney Ave. (If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print) Francis P. L. CAPORALE

4. DATE OF DEATH (Month) (Day) (Year)

July 10 19 55

5. SEX: M. 6. COLOR OR RACE: W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: Aug. 27, 1913 9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR: Months Days Mln. IF UNDER 24 HRS. Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Radio Engineer 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. C.A.A. 11. BIRTHPLACE (State or foreign country): Philadelphia, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Pasquale A. Caporale

14. MOTHER'S MAIDEN NAME:

Adelina Basta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Wm. Rowen Grant, 307 E. Girard Ave. Philadelphia 25, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 Immediate cause (a) Cardiac Arrest DUE TO

Antecedent cause(s) (b) Thrombosis Main left descending Coronary 3 hours

Diseases or conditions, if any, giving rise to the above cause DUE TO

stating underlying cause last (c) Atherosclerosis, Coronary 3 years

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John S. Ball

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 11 July 55.
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Trans. & Burial

DATE THEREOF 7/12/55

NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery

LOCATION (City, town, or county) (State) Yeadon, Pennsylvania

DATE REC'D BY LOCAL REG. 7-12-55

REGISTRAR'S SIGNATURE Kanessa Potter

24. FUNERAL DIRECTOR Warner C. Humphrey

ADDRESS 8434 Ga. Ave.

Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-563

BUREAU V. 3

JUL 14 1955

ED

06790

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (In this place) <u>7-55/7-7-55</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>	TOWN <u>26</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>613 Douglas Ave</u>	
3. NAME OF DECEASED: (First) <u>Mrs. Clara E. Carter</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7/10/01</u>
9. AGE last birthday: <u>54</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas Johnson</u>		14. MOTHER'S MAIDEN NAME: <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>	
		17. INFORMANT & ADDRESS: <u>William J. Carter, Bethesda</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <u>Immediate cause</u> <u>Cor-pulmonale</u>		<u>minutes?</u>
(b) <u>Antecedent cause(s)</u> <u>Massive embolus, pulmonary artery</u>		<u>minutes?</u>
(c) <u>Thrombus, iliac vein</u>		<u>weeks?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Carcinoma, sigmoid-rectum</u>		<u>2 1/2 yrs.</u>
19a. DATE OF OPERATION: <u>24 June 55</u>	19b. MAJOR FINDING OF OPERATION: <u>Operable CA sigmoid-rectum</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) <u>Rockville</u> County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Brochert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-14-55</u>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7-22-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Lincoln Park</u>
		LOCATION (City, town, or county) (State): <u>Rockville, Md.</u>
DATE REC'D BY LOCAL REG: <u>7-22-55</u>	REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>	M. FUNERAL DIRECTOR: <u>Robert L. Snowden</u>
		ADDRESS: <u>Rockville Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1955

BUREAU V. 3

6816

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>168 days</u>		OR TOWN <u>Brentwood</u>		<u>16-34-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
<u>50 National Institutes of Health</u>				<u>4404 40th St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
DECEASED: <u>Jane</u> <u>Cestone</u>		DATE: <u>July 15,</u> <u>19 55</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Aug 9, 1901</u>	
9. AGE last birthday <u>53</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>		11. BIRTHPLACE (State or foreign country): <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u> X	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>			
13. FATHER'S NAME: <u>Patrick McCairn</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Donachie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Multiple myeloma</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>June 8, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Trephining of Skull. Ventriculograms negative.</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 28, 1955</u> , to <u>July 15, 1955</u> , that I last saw the deceased alive on <u>July 15, 1955</u> , and that death occurred at <u>9:40PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>July 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>19 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-16-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Nallys Funeral Home Inc.</u>		ADDRESS <u>2200 Island Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06702

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Bethesda		42 days		TOWN Washington, D.C. 47x-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center				STREET ADDRESS (If rural give location)			
National Institutes of Health				1673 Columbia Road N.W. ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
DECEASED: (Type or Print) Helen Marie Chapman		DATE OF DEATH: July 14, 1955		F		W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 24 August 1898		9. AGE last birthday 56 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary		10B. KIND OF BUSINESS OR INDUSTRY: Unknown --		11. BIRTHPLACE (State or foreign country): Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Whelan				14. MOTHER'S MAIDEN NAME: Ella Arnold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Uremia							
ANTECEDENT CAUSE (B) DUE TO Arteritis of multiple vessels and chronic pyelonephrtis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary arteries arteriosclerosis							
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: None		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 June , 1955, to 14 July , 1955 that I last saw the deceased alive on 14 July , 1955, and that death occurred at 8:20A M, from the causes and on the date stated above.							
SIGNATURE William Morgan (by Richard Master)		ADDRESS The Clinical Center		DATE SIGNED July 14, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-18-55		NAME OF CEMETERY OR CREMATORY Acacia Park Cemetery		LOCATION (City, town, or county) (State) Cleveland Ohio	
DATE REC'D BY LOCAL REGISTRAR 7-16-55		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Martin W Hyman & Co		ADDRESS 1300 N. H. N. Ave	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

JUL 19 1955

RECEIVED

6818

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>District of Columbia</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Bethesda</u> Rural	<u>33</u> days	OR TOWN <u>Washington, D.C.</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>51</u> <u>U. S. Naval Hospital</u>		<u>229 E Street, N.W.</u>	✓
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>William</u>	(Middle) <u>Russell</u>	(Last) <u>CLATTERBUCK</u>	(Month) <u>July</u> (Day) <u>24</u> (Year) <u>19 55</u>
(Type or Print)			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-13-38</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Lather</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-----</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Ben CLATTERBUCK</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Wife Roberta CLATTERBUCK</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Infarction, Myocardial</u>			
ANTECEDENT CAUSE (B) <u>CORONARY OCCLUSION</u>			<u>1 hr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>CORONARY ATHEROSCLEROSIS</u>			<u>? yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>21 June, 19 55</u> , to <u>24 July 19 55</u> , that I last saw the deceased alive on <u>24 July</u> , 19 <u>55</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above.			
SIGNATURE OF <u>W. B. INGRAM</u>		ADDRESS <u>LCDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-27-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-24-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Caselle</u>	
24. FUNERAL DIRECTOR <u>Chambers Funeral Home</u>		ADDRESS <u>517 11th St., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 28 1955

RECEIVED

6819

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY <u>Bellevue Spring</u> OR <u>Bellevue Spring</u> TOWN <u>Bellevue Spring</u>	LENGTH OF STAY (in this place)	CITY <u>Bellevue Spring</u> OR <u>Bellevue Spring</u> TOWN <u>Bellevue Spring</u>	(If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>514 Lighthouse Drive</u>		STREET ADDRESS <u>514 Lighthouse Drive</u>	(If rural give location)
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<u>Claxton</u> (First) <u>John</u> (Middle) <u>John</u> (Last)		Date <u>July</u> (Month) <u>19</u> (Day) <u>65</u> (Year)	
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>	8. DATE OF BIRTH: <u>April 23, 1879</u>
9. AGE last birthday: <u>76</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Maryann Payne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>No</u>	
17. INFORMANT & ADDRESS: <u>Dr. Philander P Claxton - Item #2</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Right Heart failure</u>		<u>3 hours</u>
Antecedent causes (s) (b) <u>Hypertension, edema</u>		<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)
SUICIDE	OF INJURY	(COUNTY)
HOMICIDE		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1954, to July 17, 1955, that I last saw the deceased alive on July 17, 1955, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial - Home</u>		<u>July 17, 1955</u>	<u>Highland Park</u>	<u>Bellevue Spring</u>	<u>MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>7-18-55</u>	<u>Frances Potter</u>	<u>Robert A. Humphrey - E.F.D.</u>		<u>Bellevue Spring</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6820 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, film 184 8-1-55 et

06796

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Fairfax</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		<u>4 days</u>		OR TOWN <u>Fairfax</u> <u>83x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. # 2, Box 56</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mary Jewel CLUTE</u>				DEATH: <u>July 24 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>10-3-19</u>	
9. AGE last birthday <u>35 1/4</u> yrs.				IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>California</u>	
13. FATHER'S NAME: <u>Daniel HAYES</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>(Husband) George S. CLUTE, Same as above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hepatic Failure</u>						<u>1 week</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Cirrhosis of the Liver</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 July, 1955</u> , to <u>24 July, 1955</u> , that I last saw the deceased alive on <u>24 July 19 55</u> , and that death occurred at <u>6:50 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Gerald I. Plitman</u>				ADDRESS <u>G. I. PLITMAN LT MC USNR U.S. Naval Hospital, NNMC, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial transit</u>		<u>7-27-55</u>		<u>Golden Gate National</u>		<u>San Bruno, California</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Carrelly</u>		24. FUNERAL DIRECTOR <u>R. A. Pumphrey Funeral Home</u>		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

BUREAU V. S.

JUL 28 1955

RECEIVED

6821

Item 4, Film 184 7-20-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY MONTGOMERY CITY (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN TOWN FOREST GLEN HOSPITAL OR INSTITUTION OR STREET ADDRESS Dea. Garden Nursing Home			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY MONTG. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FOREST GLEN, SILVER SPRING STREET ADDRESS (If rural give location) 1		
3. NAME OF DECEASED: (First) IDA (Middle) E. (Last) COLE			4. DATE (Month) (Day) (Year) OF DEATH: July 13, 1955		
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 7-5-1866	9. AGE last birthday 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: ROBERT NELSON			14. MOTHER'S MAIDEN NAME: MARY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS: Mrs. Ida Pfeiffer 310- Phila. Av. TAKOMA PARK MD.					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) TERMINAL HEART FAILURE					
ANTECEDENT CAUSE (B) BRONCHO PNEUMONIA					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) CEREBRA ARTERIOSCLEROSIC.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: 6		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan., 1955 , to July 13, 1955 , that I last saw the deceased alive on July 11, 1955 , and that death occurred at 8:03 P.M. from the causes and on the date stated above. SIGNATURE Robert J. Philadelpo ADDRESS M.D. KENSINGTON, MD. 7-13-55 DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-55		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery LOCATION (City, town, or county) (State) Smithland Md	
DATE REC'D BY LOCAL REGISTRAR 7-14-55		REGISTRAR'S SIGNATURE Francis Potter		24. FUNERAL DIRECTOR J. W. Gibson ADDRESS Wash. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 18 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural
 TOWN Bethesda Rural 4 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fairfax Rural 83X-3
 STREET ADDRESS (If rural give location) Route III, Box 337A

3. NAME OF DECEASED:

(First) (Middle) (Last)
Donald Brian COLLIER

4. DATE (Month) (Day) (Year)
 OF DEATH: July 31 1955

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH:

7-27-55

9. AGE last birthday

IF UNDER 1 YEAR Months Days Hours Min.
4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Bethesda Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

William Warren COLLIER

14. MOTHER'S MAIDEN NAME:

Mary Marjorie DRAKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
None

17. INFORMANT & ADDRESS:
Father William Warren COLLIER
Same as above

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.5

IMMEDIATE CAUSE

(A)

CEREBRAL HEMORRHAGE

INTERVAL BETWEEN ONSET AND DEATH

4 days

ANTECEDENT CAUSE (S)

DUE TO

(B)

PREMATURITY

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 July, 1955 to 31 July, 1955 that I last saw the deceased alive on 31 July, 1955, and that death occurred at 9:55 P M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

G. J. MAGNANTLTJG MC USNU.S. Naval Hospital, NMMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial8-4-55Arlington NationalArlington, Virginia

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-1-55Mary E. GanellyIves Funeral Home2847 Wilson Boulevard, Arlington, Virginia

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68223
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Cherry Chase</i>		LENGTH OF STAY (in this place) <i>20 A.</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Wash.</i> <i>47x-3</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cherry Chase Country Club</i>				STREET ADDRESS (If rural, give location) <i>1511 T St NW</i> ✓			
3. NAME OF DECEASED: (First) <i>Collie</i> (Middle) <i>Crump</i> (Last)				4. DATE OF DEATH (Month) <i>July</i> (Day) <i>14</i> (Year) <i>1955</i>			
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>col</i>		7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <i>SINGLE</i>		8. DATE OF BIRTH: <i>45</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>CADDY</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>GOLF CLUB</i>		9. AGE last birthday: <i>45</i> yrs.		11. BIRTHPLACE (State or foreign country): <i>NORWOOD, NORTH CAROLINA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME: <i>FRANK CRUMP</i>			
14. MOTHER'S MAIDEN NAME: <i>FANNIE PARKER</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<i>sudden death</i>
420.1 Immediate cause (a) <i>Coronary occlusion</i> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>7-14-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>7-15-55</i>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <i>Wright P.C.</i>	
DATE REC'D BY LOCAL REG. <i>7-16-55</i>		REGISTRAR'S SIGNATURE <i>Bea M. Thompson</i>		24. FUNERAL DIRECTOR <i>John T. China & Co.</i>		ADDRESS <i>901-32nd St</i>	

54.

BUREAU Y. S.

JUL 19 1955

RECEIVED

6824

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 2 hrs.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>10204 Oldfield Dr.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <u>Thomas George Davies</u>				<u>July 10 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>May 3, 1898</u>	9. AGE last birthday: <u>57</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk Political Party</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Political Party</u>		11. BIRTHPLACE (State or foreign country): <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>George Davies</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>188-12-82109M</u>		17. INFORMANT & ADDRESS: <u>M. Roy L. Davies Kensington, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>163X Terminal Bronchopneumonia</u>						3 days	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Carcinoma of the right lung</u>						10 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (260X) (C) <u>Myocardial Coronary Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Widowed</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Feb.</u> , 19 <u>55</u> , to <u>10 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>55</u> , and that death occurred at <u>6:10 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. Blain Tibbald</u>		ADDRESS <u>8218 Wisconsin Ave - Bethesda</u>		DATE SIGNED <u>10 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Shp + burial</u>		DATE THEREOF <u>7/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washburn St. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Gorantown, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-11-55</u>		REGISTRAR'S SIGNATURE <u>Bea M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

1955

ED

6825

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		<u>3 days</u>		OR TOWN <u>Washington, D.C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1046 Wahler Place, S.E.</u> ✓			
3. NAME OF DECEASED: (First) <u>John</u>		(Middle) <u>"D"</u>		(Last) <u>DI BENEDETTO</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 30 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>27 July 1955</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>-----</u>	11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Pietro DI BENEDETTO</u>				14. MOTHER'S MAIDEN NAME: <u>Juliette BOURQUE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>170</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT & ADDRESS: <u>Father Pietro DI BENEDETTO</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>760.5 Intracranial hemorrhage</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 July, 1955</u> to <u>30 July, 1955</u> , that I last saw the deceased alive on <u>30 July, 1955</u> , and that death occurred at <u>6:23 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Pearson</u>				ADDRESS		DATE SIGNED	
H. A. PEARSON LTJG MC USN U.S. Naval Hospital, NMMC Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial transit</u>		<u>8-3-55</u>		<u>St. Michael</u>		<u>Boston, Massachusetts</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-30-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Gannelly</u>		24. FUNERAL DIRECTOR ADDRESS <u>R. A. Pumphrey Funeral Home</u> <u>7557 Wisconsin Avenue, Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

6773

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Va.</i>	COUNTY <i>Prince Williams</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
17 TOWN <i>Takoma Park.</i>	18 days	OR TOWN <i>Wokeville 832-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sen & Hosp.</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Mollie Elizabeth Diehl</i>		OF DEATH: 7 30 1955	
5. SEX: <i>fe</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>3-12-82</i>
9. AGE last birthday <i>73</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Hswf</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Samuel Hedrick</i>		14. MOTHER'S MAIDEN NAME: <i>Nancy Kerlin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT & ADDRESS: <i>Hospital Records Takoma Park Md.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Carcinoma of Stomach</i>			
ANTECEDENT CAUSE (S) DUE TO (B) <i>and/or Pancreas.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>17-19-55</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Inoperable Carcinoma - Stomach - & Pancreas</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/12</i> , 19 <i>55</i> , to <i>7/30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7-30</i> , 19 <i>55</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Arthur I. Parsaell</i>		ADDRESS <i>M.D. 900 17th St. DC</i>	
DATE SIGNED <i>7-30-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8/2/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Valley View</i>		LOCATION (City, town, or county) (State) <i>Wokeville Va</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 30, 1955</i>		REGISTRAR'S SIGNATURE <i>J. Herman Dodel</i>	
24. FUNERAL DIRECTOR <i>F. Kuehn</i>		ADDRESS <i>Hyattsville Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INVESTIGATIVE OF DEATH

BUREAU V. S.

AUG 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6826
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>20.4</u>		TOWN <u>Bethesda</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>				STREET ADDRESS (If rural, give location) <u>5526 Dorsey Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Emily Dorsey</u>				<u>7-18-55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Apr. 1, 1869?</u>	9. AGE last birthday: <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Titany land</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Reuben West</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>James Dorsey, 5526 Dorsey Lane (Son)</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u>				<u>sudden</u>			
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause (c)							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>7-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF <u>7-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-22-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	

RECEIVED

JUL 25 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6827

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06804

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>3900 Saul Rd.</u>		1	
3. NAME OF DECEASED: (First) <u>Baby</u> (Middle) <u>Girl</u> (Last) <u>Ehrich</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 24 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>July 23 1955</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday (If under 1 year) yrs. Months Days		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Louis Walter Ehrich</u>		14. MOTHER'S MAIDEN NAME: <u>Olive May Whittington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Father - 3900 Saul Rd.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>762.5 Atelctasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Failure of lung expansion</u>				<u>14 hrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Prematurity (28 weeks)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/23 1955</u> , to <u>7/24 1955</u> , that I last saw the deceased alive on <u>7/24 1955</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Michael J. Buckley</u>				DATE SIGNED <u>7/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		4. FUNERAL DIRECTOR <u>Robert R. Humphrey</u>		ADDRESS <u>Bethesda Md.</u>	

BUREAU V. S.

AUG 1 1955

RECEIVED

6828

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND <u>MD</u>	STATE <u>MD</u>	COUNTY <u>MONTGOMERY</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>X</u> TOWN	<u>4 days</u>	<u>BETHESDA</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90</u> <u>RESMORE SANITARIUM</u> <u>BETHESDA, MD.</u>		<u>5623 HUNTINGTON PARKWAY</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH:	
<u>WILLIAM FENTRESS ELLIOTT</u>		<u>JULY 25</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>M</u>	<u>W</u>	<u>W</u>	<u>18 July 1873</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>82</u> yrs.		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>MORTICIAN</u>		<u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>JOHN WESLEY ELLIOTT</u>		<u>MARIA WOODEND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>			
17. INFORMANT & ADDRESS:			
<u>LEONARD I. BARRETT Bethesda, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>331X</u> <u>Uremia</u>		<u>approx one month</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) DUE TO		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
<u>Cerebral Vascular Accident on 14 May 1955 resulting in mild paresis of both</u>	

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
<u>0</u>	<u>left extremities</u>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 July, 1955, to 25 July, 1955, that I last saw the deceased alive on 25 July, 1955, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>Jack W. Sanders</u>	<u>M.D. Calvin Johns md</u>	<u>25 July 55</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal Burial</u>	<u>7-25-55</u>		<u>Washington, D.C.</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>7-28-55</u>	<u>Bessie M. Thompson</u>	<u>W. W. Chambers Co</u>	<u>1400 Chapin St NW Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 1 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6823
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06806
Reg. Dist. 216
No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Poolesville</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Charles Thomas Ernst</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7-17-55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>6-17-53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Mont. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME: <u>George Milton Ernst</u>				14. MOTHER'S MAIDEN NAME: <u>Erma Hagenbaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Norman Smith - Box 28, Beallsville</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>9 days</u>
Immediate cause (a) <u>Shock</u> DUE TO Antecedent cause(s) (b) <u>1st and 2nd degree burns resulting</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>about 3/4 of today's burns</u> stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>home</u>)		21c. (City or town) (County) (State) <u>Poolesville Montg Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-8-55-1:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Playing with matches at home</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brachant</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Road Oak</u>		LOCATION (City, town, or county) (State) <u>Faithsburg Md.</u>	
DATE REC'D BY LOCAL REG. <u>July 20-55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Frederic B. Garton, Faithsburg Md.</u>			

RECEIVED

MIL 22 1965

BUREAU V. S.

6830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>District of COLUMBIA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u> Rural				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>57</u> <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1331 Ives Place S.E.</u> ✓			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<u>Martin</u> (N) <u>EURKOOS</u>		OF DEATH: <u>July</u> <u>25</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9-10-79</u>	<u>75</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Musician</u>				<u>U. S. Navy</u>		<u>Lithuania</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Vincent EURKOOS</u>				<u>Veronica DOUNIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> ✓ <u>Unknown</u>				<u>Unknown</u>		<u>Wife Louise C. EURKOOS</u> <u>Same as above</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE				(A) <u>myocardial infarction</u> <u>23 hrs</u>			
ANTECEDENT CAUSE (S)				(B) <u>CORONARY OCCLUSION</u> <u>23 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>CORONARY ATHEROSCLEROSIS</u> <u>8 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>24 July, 1955</u> , to <u>25 July, 1955</u> , that I last saw the deceased alive on <u>23 July, 1955</u> , and that death occurred at <u>3:30A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. B. Ingram</u>				ADDRESS <u>MC USN U.S. Naval Hospital, NMMC, Bethesda Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-29-55</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-25-55</u>		<u>Mary E. Gately</u>		<u>Chambers Funeral Home</u>		<u>517 11th Street, S.E., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 28 1955

BUREAU V. S.

6831

CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>KENSINGTON</u>		6/14/55-7/3/55		TOWN <u>SILVER SPRING</u> 56			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)			
90 <u>KENSINGTON GARDENS NURSING HOME</u>		3000 McCOMAS AVE		704 Hankin St.			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Sophie</u>		(Middle) <u>Fisher</u>		(Last)	
4. DATE (Month) (Day) (Year)		OF DEATH: <u>7-3-1955</u>					
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>Sept 16/1872</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Henry Fisher</u>				14. MOTHER'S MAIDEN NAME: <u>Regina</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Anna Vierling, 704 Hankin St. Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
332X IMMEDIATE CAUSE				(A) <u>Cerebral Thrombosis</u> 3 days			
ANTECEDENT CAUSE (S)				(B) <u>Cerebral arteriosclerosis</u> 5 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(C) <u>Generalized arteriosclerosis</u> 15 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Pulmonary edema</u> 2 days			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>(over)</u>			
22. I hereby certify that I attended the deceased from <u>2 July</u> , 19 <u>55</u> , to <u>3 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>55</u> , and that death occurred at <u>1:15 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walter J. White</u>		M. D. <u>11/1/54</u>		ADDRESS <u>60 Ave Hhd</u>		DATE SIGNED <u>July 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7/5/55		Ft. Lincoln Cemetery		Prince George County, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-5-55		<u>Frances Catter</u>		<u>Warner & Humphrey</u>		8434 Ga. Ave. Silver Spring, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 July 55.

I saw this patient for D. M. Cross
who was on vacation the 2 & 3 July 55.

Her history shows a gradual downhill
course since admission to Kensington
Audens & more rapid deterioration beginning
30 June 55.

M. J. W. to M. D.

BUREAU V. S.

JUL 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06809

6832

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Fairfax</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>18-E. Monroe Ave.</u>			
3. NAME OF DECEASED: (First) <u>Battie</u> (Middle) <u>Justis</u> (Last) <u>Fleming</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>1877</u>	
				9. AGE last birthday <u>78</u> yrs		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>William M. Justis</u>				14. MOTHER'S MAIDEN NAME: <u>Hevianna Sanford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S ADDRESS: <u>Phyllis E. Suburban Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Wrenia</u>						<u>14 days</u>	
DUE TO <u>Chronic pyelonephritis</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerosis, generalized</u>						<u>15 years</u>	
19A. DATE OF OPERATION: <u>0</u>						19B. MAJOR FINDINGS OF OPERATION: <u>Hypertensive Cardiovascular disease</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/5</u> , 19 <u>55</u> , to <u>7/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>55</u> , and that death occurred at <u>3:01 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Boale</u>				M. D.		DATE SIGNED <u>July 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>None</u>		DATE THEREOF <u>July 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Alexandria Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>7/9/55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>		FUNERAL DIRECTOR <u>St. N. Demaine</u>		ADDRESS <u>520 S. Washington St. Alex. Va.</u>	

BUREAU V. 3

JUL 13 1955

RECEIVED

6833

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06810

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>3 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	OR TOWN <u>Silver Spring</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1604 South Springwood Drive</u>		STREET ADDRESS (If rural give location) <u>1604 South Springwood Drive</u>	
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>W.</u> (Last) <u>Forni</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 15 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 11, 1909</u>
9. AGE last birthday: <u>45</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineer - Wash. Sub. Sanitary Comm.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fairview, Ohio</u>	
11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>George W. Forni</u>		14. MOTHER'S MAIDEN NAME: <u>Mollie Workman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-8695</u>	
17. INFORMANT & ADDRESS: <u>Mary H. Forni, 1604 So. Springwood Drive, SS</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Cardiac failure</u>			<u>10 min</u>
ANTECEDENT CAUSE (S): (B) <u>Coronary thrombosis & infarction</u>			<u>36 hrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerotic vasc. disc.</u>			<u>—</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar</u> , 1955, to <u>July</u> , 1955 that I last saw the deceased alive on <u>15 July 1955</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ernest E. Harmon</u>		ADDRESS: <u>M. D. 9301 Calverton Rd Silver Spring, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>Francis Potter Warner</u>	
24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF DEATHS

BUREAU V. E.

JUL 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6834 Items 1,7, Film G184 7-15-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Kensington, Md.</u>				STREET ADDRESS (If rural give location)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll Hall Sect.</u>				H007 President			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DONALD FRASER				OF DEATH: July 8 1955			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct 15 1867</u>	
9. AGE last birthday: <u>87</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Scot.</u>		11. CITIZEN OF WHAT COUNTRY: <u>Scotland</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clergy</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>John A.C. FRASER</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Hallas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Mrs J.A. Nolan Daughter</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDITIS</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>CHRONIC MYOCARDITIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>SENILITY</u>							
19A. DATE OF OPERATION: <u>NONE</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>NONE</u>			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>NONE</u>			
22. I hereby certify that I attended the deceased from <u>JAN. 9, 1955</u> , to <u>July 8, 1955</u> , that I last saw the deceased alive on <u>July 8, 1955</u> , and that death occurred at <u>1 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry London</u> M.D. <u>5206 NORWAY DR. CHERRY CHAPEL, MD</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-12-55</u>		<u>Wells River Cem.</u>		<u>Wells River VT.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-8-55</u>		<u>Frances Potter</u>		<u>Local Funeral Home</u>		<u>4812 99th ave NW Wash</u>	

BUREAU V. P.

JUL 12 1955

RECEIVED

6835

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Le Deau Gardens Rest Home</u>	STREET ADDRESS (If rural give location) <u>4221 Everett St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lewis G. FRAZIER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 3, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3-28-1864</u>
9. AGE last birthday <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Doctor Med. Ret. Medicine</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Oxford, No. Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME: <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS: <u>Karl B. Frazier Son, 4221 Everett St. Kensington, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Branchopneumonia, bilateral</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Generalised arteriosclerosis, advanced</u>			<u>10 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY <u>street</u> , office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stewart H. Haff</u>		DATE SIGNED <u>July 3, 1955</u>	
M. D. <u>3921 Ingomar St. Co.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-6-55</u>	NAME OF CEMETERY OR CREMATORY <u>Kingston Cem.</u>	LOCATION (City, town, or county) (State) <u>Somerset Co. New Jersey</u>
DATE REC'D BY LOCAL REGISTRAR <u>7/4/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1955

RECEIVED

6836

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

COUNTY **Montg.** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg Rural** LENGTH OF STAY **77 yrs**
 OR and give nearest town (in this place)
 TOWN **Gaithersburg Rural**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Montg**
 CITY (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg**
 OR TOWN **Gaithersburg**
 STREET ADDRESS **Rural** (If rural give location)

3. NAME OF DECEASED:

(First) **Martha** (Middle) **Jane** (Last) **Frazier**

4. DATE OF DEATH: (Month) **July** (Day) **7** (Year) **1955**

5. SEX:

Female

6. COLOR OR RACE **Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Widow**

8. DATE OF BIRTH: **Apr 3-1878**

9. AGE last birthday: **77 yrs.** IF UNDER 1 YEAR: Months **3** Days **4** Hours **1** Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: **House Wife**

10b. KIND OF BUSINESS OR INDUSTRY: **Home Work**

11. BIRTHPLACE (State or foreign country): **Gaithersburg. Rural. Md.**

12. CITIZEN OF WHAT COUNTRY: **U.S.A.**

13. FATHER'S NAME:

John H. Chase

14. MOTHER'S MAIDEN NAME:

Matilda Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Rosa L. Snowden. Gaithersburg. Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage**Hypertension**

Interval Between Onset And Death

2 days**8 yrs**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 1, 1954**, to **July 7, 1955**, that I last saw the deceased alive on **July 6, 1955**, and that death occurred at **6:00 PM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF **7-11-55**

NAME OF CEMETERY OR CREMATORY **Brook Grove**

LOCATION (City, town, or county) (State) **Laytonsville. Md.**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 10, 1955 **Abner L. Cook** **Ernest C. Gartner, Gaithersburg. Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 12 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6837				06814			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
Items 18-22 Film 6184 8-2-55 am							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Reg. Dist. No. 216			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>4 yrs.</u>		TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4505 N. Chelsea st</u>				STREET ADDRESS (If rural, give location) <u>4505 N. Chelsea st</u>			
3. NAME OF DECEASED: (First) <u>Gouldie</u>		(Middle) <u>Montana</u>		(Last) <u>Frisby</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-12-1903</u>	
9. AGE last birthday: <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mont.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>John W. Huffman</u>		14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Roy E. Frisby (husband) Same as Item 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
971.2 Immediate cause (a) <u>Carbolic acid poisoning (suicide)</u>							
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-23-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF: <u>7-23-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill</u>		LOCATION (City, town, or county) (State): <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert W. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. E.

JUL 25 1955

RECEIVED

U.S. GOVERNMENT PRINTING OFFICE

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6838

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06815

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>md.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>31 days 6 hrs.</u>		STREET ADDRESS (If rural give location) <u>7208 Oakridge Ave.</u>		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) <u>Sona</u> (Middle) <u>Lea</u> (Last) <u>Fuller</u>		4. DATE (Month) <u>7</u> (Day) <u>5</u> (Year) <u>1955</u>		DATE OF DEATH: <u>7-5-55</u>		DATE OF DEATH: <u>7-5-55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-8-87</u>	
9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR: <u>5</u> Months <u>27</u> Days		IF UNDER 24 HRS. <u>1</u> Hour <u>5</u> Min.		IF UNDER 24 HRS. <u>1</u> Hour <u>5</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Tipton, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Henderson</u>				14. MOTHER'S MAIDEN NAME: <u>Minnie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Stephen Fuller - Husband</u> <u>7208 Oakridge Ave Cherry Chase</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6/5-1/5/55	
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>							
ANTECEDENT CAUSE (S) (B) <u>Cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Chronic congestive heart failure</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-5-55</u> , to <u>7-5-55</u> , that I last saw the deceased alive on <u>7-5-55</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George A. Gray, Jr.</u>				DATE SIGNED <u>7/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Jessie M. Thornton</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MIL 8 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

6774

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>21 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Rainier</u>	<u>16-16-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hosp.</u>		STREET ADDRESS (If rural give location) <u>3370 Chillum Rd APT. #101</u>	<u>✓</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Frank Biers Gallagher</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7 - 3 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-9-88</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during working life, even if retired): <u>Not Known</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Govt Printing Off.</u>	
11. BIRTHPLACE (State or foreign country): <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer - USA.</u>	
13. FATHER'S NAME: <u>Michael Gallagher</u>		14. MOTHER'S MAIDEN NAME: <u>Jane Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WWI Army</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u> <u>Washington Sanitarium & Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>450.1</u> <u>Congestive Cardiac Failure</u>			<u>Terminal</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Diabetic Gangrene</u>			<u>Three weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Arteriosclerosis</u>			<u>? yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/13/55</u> , to <u>7/3/55</u> , that I last saw the deceased alive on <u>7/3/55</u> , and that death occurred at <u>9/20 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Robert A. Hare</u>		ADDRESS <u>M. D. Takoma Park, Md.</u> DATE SIGNED <u>7/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>		LOCATION (City, town, or county) (State) <u>Colman Manor, Pa. Colo. Mo</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July-5-1955</u>		REGISTERAR'S SIGNATURE <u>J. William Dodd</u>	
24. FUNERAL DIRECTOR <u>Wm. Chambers</u>		ADDRESS <u>High Falls, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

BUREAU V. 1

JUL 7 1955

RECEIVED

6833

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
TOWN <u>Bethesda</u>		<u>6 days</u>		TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>12220 Bluehill Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Francisco Guarda Galope</u>				<u>July 13 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 17, 1885</u>	
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days		11. BIRTHPLACE (State or foreign country): <u>Manila, P. I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chef</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Manila, P. I.</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Wife, Virginia Galope-above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>							<u>6 Days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral atherosclerosis.</u>							<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension, arterial.</u>							-
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> , to <u>July 13, 1955</u> that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>4:35</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>James A. Roberts</u>				ADDRESS <u>M. D. 8907 Georgia Ave. Silver Spring, Md</u>		DATE SIGNED <u>July 13, 1955</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>JULY 13 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JULY 16 1955</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W K Huntman</u>		ADDRESS <u>5732 Georgia Ave Washington DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 19 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

6840

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda</u> <u>Rural</u>		<u>1 Hr 20 min</u>		TOWN <u>Suitland</u> <u>16X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>4775 Huron Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Michael Paul Galutzi</u>				<u>July 3 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>11-1-09</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinest</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Capitol Airlines</u>		9. AGE last birthday <u>45</u> yrs.	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME: <u>Joseph GALLUZO</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>578 44 1973</u>		17. INFORMANT & ADDRESS: <u>Wife Alwilda E. GALUTZI</u> <u>Same as above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 hour</u>	
ANTECEDENT CAUSE (S) <u>Coronary Atherosclerosis</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3 July</u> , 1955, to <u>3 July</u> , 1955, that I last saw the deceased alive on <u>3 July</u> , 1955, and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNED <u>W. PEABODY JR</u>				ADDRESS <u>U. S. Naval Hospital, NMHC Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>7-7-55</u>			
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-3-55</u>				REGISTRAR'S SIGNATURE <u>Mary E. Cassella</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				ADDRESS <u>1661 Goodhope Road, S.E. Anacostia, D.C.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 214

1. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING
 TOWN SILVER SPRING LENGTH OF STAY (in this place) YRS
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 827 PHILADELPHIA AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY MONTGOMERY
 CITY (If outside corporate limits write RURAL and give nearest town) SILVER SPRING
 OR TOWN SILVER SPRING
 STREET ADDRESS (If rural, give location) 827 PHILADELPHIA AVE.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ROBERTEDWARDGARDNER

4. DATE OF DEATH

(Month)

(Day)

(Year)

JULY311955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MWJUNE 19, 190847 yrs.

Months

Days

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): MALE NURSE10b. KIND OF BUSINESS OR INDUSTRY: GENERAL DUTY NURSING11. BIRTHPLACE (State or foreign country): SUNDERLAND, ENGLAND12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME:

ROBERT GARDNER

14. MOTHER'S MAIDEN NAME:

ELIZABETH HARTY15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO16. SOCIAL SECURITY No.: 578-03-5544

17. INFORMANT & ADDRESS:

EDITH D. GARDNER 827 PHILADELPHIA AVE., SILVER SPRING, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. Broschart

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

7-4-5523. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-5-55Frances CollierArthur Palmer254 CARROLL ST. N.W., TAKOMA PARK 12, D.C.

RECEIVED

JUL 8 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06820

6775

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Dist. of Cal.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
17 TOWN <u>Takoma Park</u>	22 days	<u>Washington</u>	47X23
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
75 <u>Washington Sanitarium and Hospital</u>		6416 31st St. N.W.	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH:	
Mary Elizabeth Garland		7 2 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	Cauc.	Widow	11 - 1 - '79
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
75 yrs.	Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Hswt		D.C.	U.S.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
William Bowles		Melinda Mattingly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
Hospital Record			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
155X			
IMMEDIATE CAUSE (A)			
Anterior carcinoma-liver			?
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
Arteriosclerotic heart disease			years
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
2			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
OF INJURY		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-6-55, 1955, to 7-2-55, that I last saw the deceased alive on 7/2/55, and that death occurred at 5:40 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Francis R. Richard		7/1/55	
M.D. 7717 Alhambra N.W. Wash. D.C.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
7-6-55		Mt. Olivet, Gen	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
7-5-55		J.H. Pines Co, 2901-14th St. N.W. Wash.	

RECEIVED

JUL 8 1955

BUREAU V. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6842
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06821
Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>D.C.</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural, give location) <u>2610 Spencer Road</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>Ben Hill Marriett</u>		<u>July 31</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>Married</u>	<u>April 24, 1886</u>	<u>69</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Own Business grocery</u>				<u>South Carolina</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Louis Marriett</u>				<u>Agnes C. Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Mrs. Evaline Marriett</u> <u>2610 Spencer Rd., Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
900.0		(a) <u>Extensive cerebral contusions</u>				<u>sudden</u>	
Immediate cause		DUE TO					
Antecedent cause(s)		(b) <u>Extensive fracture of Basal skull</u>				<u>1 hour</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO					
		(c) <u>Fall down stairs</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY <u>home</u>)		21c. (City or town) (County) (State)			
		<u>Silver Spring monty md</u>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-31-55- 8:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down basement steps</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Broschart</u>						<u>8-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Trans. & Burial</u>		<u>8/2/55</u>		<u>Memorial Park Cemetery</u>		<u>St. Petersburg, Florida</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8/2/55</u>		<u>Bessie M. Thompson</u>		<u>Wanner & Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

AUG 4 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06822			
Item 18 Film G184 8-5-55 ans		CERTIFICATE OF DEATH	
6776		Reg. Dist. No. 223	
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND ✓	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
TOWN <u>Takoma Park</u>	TOWN <u>Takoma Park</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>	STREET ADDRESS (If rural give location) <u>1201 Kirk Lynn Ave</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Henry (NMN) Gay</u>		DATE OF DEATH: <u>7</u> <u>24</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>4-12-'05</u>
9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME: <u>Riccardo Gay</u>		14. MOTHER'S MAIDEN NAME: <u>Christina Gamini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records Washington Sanitarium & Hospital</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		8 days	
IMMEDIATE CAUSE (A) <u>ACUTE Meningoencephalitis</u>			
ANTECEDENT CAUSE (S) (B) <u>Viruses of undetermined type</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 17, 1955</u> , to <u>July 24, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Russell B. Arnold</u>		DATE SIGNED <u>7-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem.</u>		LOCATION (City, town, or country) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/27/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>The S. H. Huns Co 2901-14 St NW</u>	

RECEIVED

6843

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>56 Silver Spring</u>	LENGTH OF STAY (in this place) <u>9 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>56 Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1602 Cody Drive</u>	STREET ADDRESS (If rural give location) <u>1602 Cody Drive</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>ZACHARIAH THOMAS GOLDSMITH</u>		<u>July 23 19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Dec. 27, 1887</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired (10 yrs.) Builder</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Builder</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>James S. Goldsmith</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Aldridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Spring, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>331X</u>		<u>7 mo</u>	
ANTECEDENT CAUSE (S):		<u>3 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		<u>3 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign heart failure</u>			
19A. DATE OF OPERATION: <u>Nov 0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-8</u> , 19 <u>55</u> to <u>7-23</u> , 19 <u>55</u> that I last saw the deceased alive on <u>7-22</u> , 19 <u>55</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.			
SIGNED <u>John H. Rogers</u> M. O. <u>1918 University Rd</u> ADDRESS <u>7-23-55</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
24. FUNERAL DIRECTOR <u>Warner C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1955
BUREAU V. S.

6777

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PRINCE GEORGES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>		LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BRENTWOOD</u>		<u>16-34-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 OAK HAVEN REST HOME</u> <u>517-Albany Ave., Takoma Park, Md.</u>				STREET ADDRESS (If rural give location) <u>3600 Jaylor St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROSE M. GRAVES</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>7 17 1955</u>			
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>MAY 11-1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>WOODSTOCK, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Merkle</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Seeman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown -</u>		17. INFORMANT & ADDRESS: <u>Thomas E. Graves Same Add</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Central Thrombosis</u>						<u>Same</u>	
ANTECEDENT CAUSE (B) <u>Anterior ch... Old central thrombosis</u>						<u>2-3 yrs ago</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Old central thrombosis, heavy heart</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>7/17/1955</u> , that I last saw the deceased alive on <u>7/14/1955</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>E. W. Hobbs</u>		ADDRESS <u>M.D. 500 Woodmont Dr. NW.</u>		DATE SIGNED <u>7/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-20-55</u>		<u>Ft. Lincoln</u>		<u>Prince Geo Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 17-1955</u>		<u>J. Wilson</u>		<u>NALLEYS Funeral Home</u>		<u>3200 R. Island Ave., Mt. Rainier, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONTINUATION OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF

1111

BUREAU V. S.

JUL 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06825

CERTIFICATE OF DEATH

Reg. Dist. No. 218

 6841
 Item 9, Film 185 8-16-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
X TOWN <u>Rural Germantown</u>		<u>4 weeks</u>		TOWN <u>Waldsburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) <u>GEORGE</u> (Middle) <u>EMORY</u> (Last) <u>GRAY</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug 11, 1876</u>	
9. AGE last birthday: <u>81</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Claf work</u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>in</u>		17. INFORMANT & ADDRESS: <u>Edward Gray Germantown Md</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X Immediate cause (a) <u>Uremia</u>							<u>5 days</u>
Antecedent causes (s) (b) <u>Arteriosclerotic Cardiovascular Renal Disease</u>							<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>29 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>28 July</u> , 19 <u>55</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Norman Smith</u>				ADDRESS <u>M.D. Barnesville</u>		DATE SIGNED <u>30 July 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 1, 1955</u>		<u>Pleasant Grove</u>		<u>Pardons</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>July 30, 1955</u>		<u>Alfred S. Cooke</u>		<u>Wm W Barboursville</u>		<u>Md</u>	

ROY
Barber

BUREAU V. S.

AUG 3 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>34 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>50 National Institutes of Health</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Alexandria</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u> <u>83X-3</u> STREET ADDRESS (If rural give location) <u>2 Enfield Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Dorothy E. Gruff</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 11, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 4, 1923</u>
9. AGE last birthday <u>31</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>7</u> IF UNDER 24 HRS.: Hours <u>7</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	
10A. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME: <u>Fred Pacitti</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Pacacio</u>		15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>187-18-8025</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Lobular pneumonia</u>			
DUE TO			
ANTECEDENT CAUSE (B) <u>Hodgkins disease</u>			
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1955</u> , to <u>July 11, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Russ M. Miller, Jr.</u>		DATE SIGNED <u>July 11, 1955</u>	
ADDRESS <u>The Clinical Center</u>			
M. D. <u>National Institutes of Health</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Delaware Co. Yeadon Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU VI 81

JUL 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06827

6846

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>X</u> TOWN <u>Bethesda rural</u>		<u>2 days</u>		TOWN <u>Washington, D.C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>640 G Street, N.E.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 1 1955</u>			
<u>James Earl HADEN</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12-1-88</u>	9. AGE last birthday: <u>66 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas HADEN</u>				14. MOTHER'S MAIDEN NAME: <u>Alice BIGGS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> ✓ <u>WW I</u>		16. SOCIAL SECURITY No. <u>577-48-1158</u>		17. INFORMANT & ADDRESS: <u>Sister Mary H. AUSTIN</u> <u>Lee Gardens, Arlington, Virginia</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Ventricular fibrillation</u>						<u>15 min</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Coronary atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>21</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 June, 1955</u> , to <u>1 July, 1955</u> , that I last saw the deceased alive on <u>1 July, 1955</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. H. GARY LT MC USN U. S. Naval Hospital, D. N. M. C. Bethesda, Maryland</u>				ADDRESS <u>Bethesda, Maryland</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 July 1955</u>		REGISTRAR'S SIGNATURE <u>Mary C. Parrelly</u>		24. FUNERAL DIRECTOR <u>S.H. HINES</u>		ADDRESS <u>2901 14th ST, NW, WDC</u>	

BUREAU V. S.

JUL 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Cabin John</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cabin John</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Dr.</u>				STREET ADDRESS <u>Riverside Drive</u> (If rural, give location)			
3. NAME OF DECEASED: (First) <u>DAVID</u> (Middle) <u>V.</u> (Last) <u>HALL</u>		4. DATE OF DEATH		5. DATE OF BIRTH		6. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
(Type or Print)		<u>July 4</u> 19 <u>55</u>		<u>Aug. 8, 1890</u>		<u>64</u> yrs. <u>10</u> Months <u>26</u> Days <u>0</u> Hours <u>5</u> Min.	
7. SEX: <u>Male</u>	8. COLOR OR RACE: <u>White</u>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	10. DATE OF BIRTH: <u>Aug. 8, 1890</u>		11. AGE last birthday: <u>64</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Maint. U.S. Gov</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>213-16-2684</u>		17. INFORMANT & ADDRESS: <u>Step-son John W. Skinner-Box 346 Gaithersburg, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u> DUE TO						<u>Found dead - b-1</u>	
Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Bruchard</u>		M. D. <u>Bessie M. Thompson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>7-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
DATE REC'D BY LOCAL REG. <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

JUL 8 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06829
6848 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
56 <u>Silver Spring, Md.</u>		1 day		Washington, D. C. 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paint Branch Nursing Home</u>				STREET ADDRESS (If rural give location) <u>5413 - 5th St., N. W.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last)				July 26 1955			
JAMES EDWARD HALL							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white	single	May 14, 1903	52 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Mechanic				Automobile		Virginia	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Edward Hall				Margaret Minor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
5 MI				579-03-5580		5413 5th St., N. W. Miss Mildred E. Hall, Washington, D. C.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>GENERALIZED CARCINOMATOSIS</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>CARCINOMA OF PANCREAS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 23</u> , 1955, to <u>July 26</u> , 1955, that I last saw the deceased alive on <u>July 23</u> , 1955, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George P. George</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				July 28, 1955 Oakwood Cemetery		Falls Church, Virginia	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
7-27-55				Frances Potter		Wm. C. Pumphrey Silver Spring, Md.	

RECEIVED

AUG 3 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6849 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06830
 Item 14 film 184 7-27-55 et
CERTIFICATE OF DEATH Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Bethesda</i>		<i>14 days</i>		OR TOWN <i>Silver Spring</i>		<i>56</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hosp.</i>				STREET ADDRESS (If rural give location) <i>10207 Haywood Drive</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Orlando Graham Hall</i>				<i>July 19 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH: <i>October 28-1873</i>	9. AGE last birthday <i>82</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Pharm.</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Drugs</i>		11. BIRTHPLACE (State or foreign country): <i>Washington - D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME: <i>Columbus Hall</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <i>Jonathan L. Hall</i>				<i>10207 Haywood Dr. Silver Spring-Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Carcinoma of Colon</i>						<i>8-10 mo</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb</i> , 1954 to <i>19 July 1955</i> , that I last saw the deceased alive on <i>19 July</i> , 1955, and that death occurred at <i>9:20 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>William D. Lund</i>		M. D. <i>Silver Spring Md</i>		DATE SIGNED <i>7/9/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7/22/55</i>		NAME OF CEMETERY OR CREMATORY <i>Glenwood Cems.</i>		LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-20-55</i>		REGISTRAR'S SIGNATURE <i>Benito M. Thompson</i>		24. FUNERAL DIRECTOR		ADDRESS <i>The S.W. Threels 2901-14th St. N.W. Wash. D.C.</i>	

BUREAU V. S.

JUL 25 1955

RECEIVED

6850

CERTIFICATE OF DEATH

Reg. Dist. No. 218.....

1. PLACE OF DEATH:

COUNTY Montg MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) Gaithersburg. Rural 6yrs
 TOWN
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montg.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Gaithersburg
 STREET ADDRESS Rout #3 (If rural give location)

3. NAME OF DECEASED:

(First)

Mary

(Middle)

Elizabeth

(Last)

Hanger

4. DATE OF DEATH:

(Month)

(Day)

(Year)

741955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widow

8. DATE OF BIRTH:

Mar 20-1874

9. AGE last birthday:

81 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

314149

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

Home Work

11. BIRTHPLACE (State or foreign country):

Petersburg. W Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

Floyd D. Hanger

14. MOTHER'S MAIDEN NAME:

Mary C. Keptlinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mr Corbett V. Hanger, Gaithersburg. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157XImmediate cause

(a)

DUE TOAntecedent causes (s)Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

2yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to 4 July, 1955, that I last saw the deceasedalive on 3 July, 1955 and that death occurred at 1:13 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 5, 1955
Wanda L. Gode

Ernest C. Gartner, Gaithersburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 8 1955

RECEIVED

6851

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Tenn.</u>		COUNTY <u>79x3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda</u>		LENGTH OF STAY <u>14</u> in this place days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mascot</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center, NIH</u>				STREET ADDRESS (If rural give location) <u>Route 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Leon Cromwell Hargis</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 18 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 8, 1922</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Auto Service</u>		11. BIRTHPLACE (State or foreign country): <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charlie Hargis</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie Webster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		16. SOCIAL SECURITY No. <u>not available</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Carcinoma of testicle with massive</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>metastases to lungs, brain, adrenal glands, abdominal nodes</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>----</u>							
19A. DATE OF OPERATION: <u>July 7, 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>Metastatic tumor, rt. parietal region ; Metastatic tumor, occipital region</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-4-55</u> , 19 <u>55</u> , to <u>7-18-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>55</u> , and that death occurred at <u>9:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Webb</u>		ADDRESS <u>M.D. The Clinical Center, NIH</u>		DATE SIGNED <u>7/19/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Knockville</u>		LOCATION (City, town, or county) (State) <u>Tenn.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Osceola Funeral Home</u>		ADDRESS <u>4812 Georgia Ave. N.W. Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1955

BUREAU V. S.

6852

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>9308 Milroy Place</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Edwin</u> <u>Rea</u> <u>Harkness</u>		<u>July</u> <u>19</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Jan. 18, 1886</u>
		9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gen. accounting - U.S. Government</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): <u>Illinois</u>
13. FATHER'S NAME: <u>Edwin R. Harkness</u>		14. MOTHER'S MAIDEN NAME: <u>Belle Mettler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Mabel Harkness</u> <u>9308 Milroy Place, Bethesda</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>585X pneumonia, cardiac failure</u>		
ANTECEDENT CAUSE (S) (B) <u>bile peritonitis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>traumatic cholecystitis with perforation</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>chronic ulcer, previous appendectomy</u>		
19A. DATE OF OPERATION: <u>7-10-55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>perforated gall bladder, peritonitis</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>7-10-55</u> to <u>7-19-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-19-55</u> , 19 <u>55</u> , and that death occurred at <u>8:10 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>John O. Reichen</u>		ADDRESS <u>7930 Georgia Ave. Spring Md.</u>	DATE SIGNED <u>7-19-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial transit</u>	DATE THEREOF <u>7-21-55</u>	NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	LOCATION (City, town, or county) (State) <u>Peoria Co. Illinois</u>
DATE REC'D BY LOCAL REGISTRAR <u>7.20.55</u>	REGISTRAR'S SIGNATURE <u>Gerard M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

wife.

012-7847

Daughter.

Tr. 6-1607

BUREAU V. S.

JUL 22 1955

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

6853

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>56 TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10 Kensington Montgomery</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Cedar Crest Sanitation</u>		STREET ADDRESS (If rural, give location) <u>10,600 Nash Place</u>	
3. NAME OF DECEASED (First) <u>Monroe</u> (Middle) <u>MAY</u> (Last) <u>Harris</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>Female</u> 6. COLOR OR R <u>W</u>		8. DATE OF BIRTH <u>Feb 24 1885</u> 9. AGE last birthday <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Gova</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Alfred May</u>		14. MOTHER'S MAIDEN NAME <u>JULIA ESTELLE TYLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Dorothy Harris Rawlings</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.2 Immediate cause (a) <u>myocarditis</u>			
Antecedent cause(s) (b) <u>Virus pneumonia</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>3 wks 10</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY m. While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>6-30</u> , 19 <u>55</u> , to <u>July 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>55</u> , and that death occurred at <u>2:20 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>A. J. Carter</u>		DATE SIGNED <u>Aug 2, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>7-31-55</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
REGISTRAR'S SIGNATURE <u>Francis Potter</u>		24. FUNERAL DIRECTOR <u>Warner Co. Pumping</u>	
		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 3 1955

RECEIVED

6854

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>3910 Dresden St</u>			
3. NAME OF DECEASED: (First) <u>Naomi</u> (Middle) <u>H.</u> (Last) <u>Hartshorn</u>				4. DATE (Month) <u>July</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>4/8/98</u>	
				9. AGE last birthday <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u></u> Mins. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if temporary) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Joseph Haller</u>				14. MOTHER'S MAIDEN NAME: <u>Lucretia Wilcoxon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Hosmer P. Hartshorn, Husband</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) <u>cardiac arrest</u>						5 min	
ANTECEDENT CAUSE (S) (B) <u>chronic myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>chronic emphysema</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>10 min excision of Pectal adenoma</u>						20 min	
19A. DATE OF OPERATION: <u>1/7/27/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Pectal adenoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 1955, that I last saw the deceased alive on <u>7/27</u> , 1955, and that death occurred at <u>1240</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John O. Rolben MD</u>		ADDRESS <u>7930 Georgia Ave S.E. And</u>		DATE SIGNED <u>7-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Rockville Montg.Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MAR 3 1955

RECEIVED

6778

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u> MARYLAND				STATE <u>MD</u> COUNTY <u>12-24-2</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>TAKOMA PK.</u> LENGTH OF STAY (in this place) <u>6 mo.</u>				TOWN <u>Navre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>EBB TIDE SANIT</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
TYPE OR PRINT <u>MARY ELLEN HEALY</u>				OF DEATH: <u>7-7</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>7</u>	<u>W.</u>	<u>Single</u>	<u>May 18, 74</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>—</u>				<u>—</u>		<u>Navre de Grace MD</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thos. Healy</u>				<u>Ann B. Magee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>9</u> <u>—</u> (If Yes, give war or dates of service)				<u>—</u>		<u>Hosp. Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Renal Insufficiency</u>							
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Serubity</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> 19 <u>55</u> , to <u>July</u> 19 <u>55</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>55</u> , and that death occurred at <u>11:25 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bernard A. Fitzgibbon</u>				ADDRESS <u>M. D. 9620 Old Bladensburg Rd</u>		DATE SIGNED <u>7-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>7-11-55</u>		<u>Mt. Erin</u>		<u>Navre de Grace MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 8-1955</u>		<u>William Noel</u>		<u>Gas. T. Ryan Inc.</u>		<u>317 N. Ave. WASH. DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6855 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06837											
Certificate of Death											
Item 7, Film 184 7-25-55 et											
1. PLACE OF DEATH:						2. USUAL RESIDENCE (HOME) OF DECEASED:					
COUNTY <u>MONTGOMERY</u>			MARYLAND			STATE <u>Dist 9</u>			COUNTY <u>47X-3</u>		
CITY (If outside corporate limits, write RURAL or and give nearest town)			LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town)			OR TOWN		
X TOWN <u>KENSINGTON</u>						<u>Washington</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS						STREET ADDRESS (If rural give location)					
90 <u>CARROLL HALL</u>						<u>237 Mo. Ave N.W.</u>					
3. NAME OF DECEASED: (Type or Print)			(First) (Middle) (Last)			4. DATE (Month) (Day) (Year)					
<u>HEURY</u>			<u>C.</u>			<u>HEDRICK</u>					
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>DEC 26-1877</u>		9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:				11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>David Wick & Sons, Inc. Supt of Buildings</u>								<u>Va</u>			
13. FATHER'S NAME:						14. MOTHER'S MAIDEN NAME:					
<u>Henry Clay Hedrick.</u>						<u>RENA Liskey.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>577-10-5678</u>			17. REMARK & ADDRESS: <u>HARRISONBURG Va</u>		
18. MEDICAL CERTIFICATION											
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
422.2 IMMEDIATE CAUSE				(A) <u>ACUTE MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE (B)				DUE TO <u>CHRONIC PROSTATITIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO <u>CHRONIC MYOCARDITIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>SENILITY</u>											
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NONE</u> M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 7</u> , 1955, to <u>JULY 15</u> 1955, that I last saw the deceased alive on <u>JULY 15</u> , 1955, and that death occurred at <u>7:30 P M</u> , from the causes and on the date stated above.											
SIGNATURE <u>Francis J. Toller</u>				M. D. <u>5206 NORWAY DR</u>				DATE SIGNED <u>JULY 15-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
				<u>7-19-55</u>		<u>Fort Lincoln</u>		<u>Prince Geo Ind</u>			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR			
<u>JULY 18 1955</u>				<u>Francis J. Toller</u>				<u>2901-14th St. N.W.</u>			
								<u>Wash. D.C.</u>			

BUREAU V. 2

JUL 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6856

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06838
Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>NC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Durham</u> <u>70X-3</u>			
TOWN <u>Brookmont</u>		<u>30 min.</u>		STREET ADDRESS (If rural, give location) <u>✓</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Feder dam</u>							
3. NAME OF DECEASED: (Type or Print)		(First) <u>Charles S.</u>		(Middle) <u>Hedlin</u>		(Last)	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12-24-1910</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Car Lot Attn</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>44</u> yrs. <u>6</u> Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>		4. DATE OF DEATH: <u>July 2</u> 19 <u>55</u>	
11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Henry H. Hedlin</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Fuller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Yes</u>		17. INFORMANT & ADDRESS: <u>Hazel H. Dodson, sister</u> <u>815 Mary St. Durham, No. Carolina</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>929.8</u> Immediate cause (a) <u>Asphyxia</u> DUE TO <u>drowning</u> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>sudden</u> <u>death</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Feder dam</u>		21c. (City or town) (County) (State) <u>Brookmont Monty NC</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-2-55-12:53 A.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Was swimming in dam</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>7-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>7-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>7/4/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert M. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. B.

MAY 6 1955

RECEIVED

6857

06839

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u> Rural		<u>2 days</u>		TOWN <u>Midway Island</u> <u>83X-13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural, give location) <u>59 Norris Drive</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William Carol HEWITT</u>				<u>July 25 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>9-29-26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Marines</u>		9. AGE last birthday: <u>28</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>South Carolina</u>	
13. FATHER'S NAME: <u>EPharm HEWITT</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>10-21-53 to 7-25-55</u>				17. INFORMANT & ADDRESS: <u>Wife Wilhelmina HEWITT</u> <u>39 Norris Dr. Midway Island, Quantico, Va.</u>			
16. SOCIAL SECURITY No.: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Ora BASS</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Traumatic subdural hematoma with cerebral contusions and edema</u>							<u>3 days</u>
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause (c) <u>DUE TO</u> stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>highway</u>		21c. (City or town) (County) (State) <u>Mr. Stafford - N.S.R.-1</u> <u>OK</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-22-55 11 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>1</u>		21f. HOW DID INJURY OCCUR? <u>Pedestrian struck by auto</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosehart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-25-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial transit</u>		DATE THEREOF <u>7-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Charleston, S.E.</u>	
DATE REC'D BY LOCAL REG. <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>		24. FUNERAL DIRECTOR <u>R. A. PUMPHREY Funeral Home,</u>		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

JUL 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06840
 6858 Items 7, 11, Film G184 7-15-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 217.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Olney</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location) <u>1617 West Landvale Street</u>	
3. NAME OF DECEASED: (First) <u>Alfred</u> (Middle) <u>Howard</u> (Last) <u>Howard</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 1 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>4/30/74</u>
9. AGE last birthday <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Greenberry Howard</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Prettyman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
446X IMMEDIATE CAUSE (A) <u>Uremia</u>			<u>10 day.</u>
ANTECEDENT CAUSE (S) (B) <u>Chronic nephritis</u>			<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio sclerosis</u>			<u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>L</u>			
19A. DATE OF OPERATION: <u>OC</u>		19B. MAJOR FINDINGS OF OPERATION: <u>L</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/24/</u> , 1955, to <u>7/1/</u> , 1955, that I last saw the deceased alive on <u>7/1/</u> , 1955, and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/3/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lanary Spring</u>		LOCATION (City, town, or county) (State) <u>Lanary Spring Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-3-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

RECEIVED

JUL 8 1955

BUREAU V. S.

6860

CERTIFICATE OF DEATH

Reg. Dist. No. 2 17....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Montgomery</i>	MARYLAND		STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Fairbairnsburg 1st 8x</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Fairbairnsburg 1st 8x</i>	LENGTH OF STAY (in this place) <i>2 days</i>		STREET ADDRESS (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>General Hospital</i>					
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First) <i>CORA</i>	(Middle) <i>DARLINE</i>	(Last) <i>HOWARD</i>	(Month) <i>July</i>	(Day) <i>24</i>	(Year) <i>1955</i>
5. SEX: <i>FEMALE</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH: <i>JULY 24 1955</i>		
9. AGE last birthday <i>—</i> yrs.			10. BIRTHPLACE (State or foreign country): <i>Maryland</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>—</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>		
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME: <i>Kermit R. Howard</i>			14. MOTHER'S MAIDEN NAME: <i>Ertie Bernie Milton</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>4-</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT & ADDRESS: <i>Kermit R Howard</i>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <i>760.0</i>		
(A) <i>Cerebral Hemorrhage</i>		<i>1 day</i>
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
----------------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from *July 22, 1955*, to *July 24, 1955*, that I last saw the deceased alive on *July 24, 1955*, and that death occurred at *11:00 P.M.* from the causes and on the date stated above.

SIGNATURE *James P. Kern* ADDRESS *Hamascus, Md.* DATE SIGNED *July 24, 1955*

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>	DATE THEREOF <i>July 26, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Seals Home Cemetery</i>	LOCATION (City, town, or county) (State) <i>Etchison 1st 8x</i>
--	-----------------------------------	--	---

DATE REC'D BY LOCAL REGISTRAR <i>7-26 55-</i>	REGISTRAR'S SIGNATURE <i>Beatrice B Lawler</i>	24. FUNERAL DIRECTOR <i>Roy W. Barber</i>	ADDRESS <i>Gettysville</i>
---	--	---	----------------------------

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6853

06841

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u> <u>Clarksburg</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN</u> <u>Clarksburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Edward Avenue</u>				STREET ADDRESS (If rural, give location) <u>Edward Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>RICHARD</u> <u>L</u> <u>HOWARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>15</u> <u>19 55</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 25, 1899</u>	9. AGE last birthday: <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>219-03-6211</u>		17. INFORMANT & ADDRESS: <u>Jessie J. Howard</u> <u>Son, Clarksburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u></u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-15-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-18-55</u>		NAME OF CEMETERY OR CREMATORY <u>Neelsville, Maryland</u>		LOCATION (City, town, or county) (State) <u>Montgomery Co. Maryland</u>	
DATE REC'D BY LOCAL REG. <u>July 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

JUL 27 1955

BUREAU V. S.

06843

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6861

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>3 days 8 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>4300 Willow Lane</u>		1	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Johnston Howard</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7-31 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>10-31-97</u>	
9. AGE last birthday <u>57</u> yrs.		10. MONTHS <u>9</u> DAYS <u>0</u> HOURS <u>0</u> MIN.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>U.S. Agriculture</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Pittsburg, Pa.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Bakewell Howard</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Johnston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>World War II</u>		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Margaret Howard - wife</u> <u>4300 Willow Lane CC, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>4 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Cardio-vascular renal disease</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 27 1955</u> to <u>July 31 1955</u> , that I last saw the deceased alive on <u>July 30 1955</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William C. Cousens</u>		ADDRESS <u>M. D. 3922 Ingomar Rd. NW, Wash. D.C.</u>		DATE SIGNED <u>8/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/2/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6792

06844

Reg. Dist. No. 213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>26 Rockville</u>		LENGTH OF STAY (in this place) <u>E.O.A</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Congressional Airport</u>				STREET ADDRESS (If rural, give location) <u>2214 Washington Avenue</u>			
3. NAME OF DECEASED: (First) <u>W.</u> (Middle) <u>Raymond</u> (Last) <u>HUGHES</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 12, 1905</u>	
9. AGE last birthday: <u>49</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Wash. Eve. Star</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Printer</u>				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
13. FATHER'S NAME: <u>Clare R. Hughes</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Robe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>578-09-8958</u>		17. INFORMANT & ADDRESS: <u>Mary W. Hughes - Same as Item #2</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause		(a) <u>Coronary occlusion</u> DUE TO		<u>Sudden</u>	
Antecedent cause(s)		(b) <u></u> DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE <u>Frank J. Broschart</u>		M. D. <u>Robert M. Campbell</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7/28/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
DATE REC'D BY LOCAL REG. <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Keaylor</u>		LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
DATE REC'D BY LOCAL REG. <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Keaylor</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

JUL 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06845
6862
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE		COUNTY Washington, D.C.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN		3 Mo. 27 Days		District of Columbia		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital,				STREET ADDRESS (If rural give location) Sheraton Park Hotel, Room 400G			
51							
3. NAME OF DECEASED: (First) Cordell		(Middle) (n)		(Last) HULL		4. DATE (Month) (Day) (Year) OF DEATH: July 23 1955	
5. SEX: Male		6. COLOR OR RACE: Cauc.		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed		8. DATE OF BIRTH: 2 OCT 1871	
9. AGE last birthday: 83 yrs.		IF UNDER 1 YEAR: 9 Months		IF UNDER 24 HRS.: 9 Days		Hours: 9 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Government				10B. KIND OF BUSINESS OR INDUSTRY: State Department		11. BIRTHPLACE (State or foreign country): Tennessee	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME: William HULL				14. MOTHER'S MAIDEN NAME: Elizabeth RILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Mrs. Katherine ETHRIDGE (Neice) Same as item 2	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Hypertensive Cardiovascular Disease		10 yrs	
ANTECEDENT CAUSE (B) Arteriosclerosis General		10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (260X) Diabetes mellitus		10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 26 Mar., 1955 , to 23 Jul., 1955 that I last saw the deceased alive on 23 Jul., 1955 , and that death occurred at 9:00A M. from the causes and on the date stated above.					
J. W. FLYNN LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland 23 July 1955					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 26 Jul 1955		NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	
LOCATION (City, town, or county) (State) Washington, D.C.		24. FUNERAL DIRECTOR ADDRESS Gawlers Funeral Home 1756 Penn Ave., Washington, D.C.			
DATE REC'D BY LOCAL REGISTRAR 23 July 1955		REGISTRAR'S SIGNATURE Mary E. Garselly			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. I.

JUL 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06846
6863 CERTIFICATE OF DEATH Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>Manor Club</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Don R. Hutchison</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>July 17 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>12/21/1894</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Tax Attorney & Accountant</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>John R. Hutchison</u>				14. MOTHER'S MAIDEN NAME: <u>Jessie Paris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma Soft Palate</u>						<u>1 yr</u>	
ANTECEDENT CAUSE (S) (B) <u>Small Intestines</u>						<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>L</u>							
19A. DATE OF OPERATION: <u>April 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma Soft Palate, with involvement of lymph nodes</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/22/1955</u> , to <u>7/17/1955</u> , that I last saw the deceased alive on <u>7/16/1955</u> , and that death occurred at <u>7:43a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>7/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-19-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 22 1955

RECEIVED

JUL 5 - 1955

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06847

6779

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>25 Washington Sanitarium & Hospital</u>				STREET ADDRESS (If rural give location) <u>9402 Russell Road</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Theresa Sarah Irwin</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7-5-1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>10-7-01</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswf.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME: <u>Frank Vernon</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Flecknoe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>581.0 Hepatic COMA, terminal</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Cirrhosis of liver, severe</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1953, to <u>July 5</u> , 1955, that I last saw the deceased alive on <u>July 5</u> , 1955, and that death occurred at <u>6:58 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George B. Patrick</u>		ADDRESS <u>8708 Eylesville</u>		DATE SIGNED <u>7-5-55</u>		M. D. <u>Silver Spring, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/19 6-1955</u>		REGISTRAR'S SIGNATURE <u>J. Vernon Dodd</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

JUL 8 1955

RECEIVED

6864

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney	LENGTH OF STAY (in this place) 48 minutes	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laytonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital, Inc.		STREET ADDRESS (If rural give location) /	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
Jackson		July 30 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
female	colored	single	7/30/55
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Mins.
			48

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
	Charlotte Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.
	Hospital Records
17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE		
762.0		
(A) Bilateral atelectasis		45 minutes
DUE TO		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B)		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/30**, 19**55**, to **7/30**, 19**55** that I last saw the deceased alive on **7/30**, 19**55**, and that death occurred at **4/30** M, from the causes and on the date stated above.

SIGNATURE	DATE SIGNED
James D. Kern M.D.	7/30/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE REC'D BY LOCAL REGISTRAR
Buried	7-31-55
DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Aug 1 1955	Brook Grove and Laytonsville Md
REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
Gertrude B Lawler	Ray W Barber Laytonsville Md
	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15-10-53

2075201180

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06849

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>1700 Park</u>		<u>13 1/2 hrs.</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium & Hospital</u>				STREET ADDRESS (If rural, give location) <u>S. Stewart Lane</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>George</u>		<u>Preston</u>		<u>Jackson</u>		<u>7-19-55</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>Colored</u>		<u>Single</u>		<u>2-27-26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Butcher</u>		<u>-</u>		<u>Ind.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>David Jackson</u>				<u>Louise Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>-</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Multiple fractures of skull</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>39 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of skull</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>825X</u>				<u>Fracture of skull</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>R 196 W. Brittonville Monty, MD</u>		<u>Highway</u>		<u>15</u>		<u>MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>M.</u>		<u>While at work</u>		<u>Passenger in auto accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Byers</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>7-19-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-23-55</u>		<u>Coleville, MD</u>		<u>Flood House</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-23-55</u>		<u>Thames</u>		<u>Robert A. Smith</u>		<u>Rockville, MD</u>	

BUREAU V. S.

JUL 26 1955

RECEIVED

6865

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Kensington	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10325 Summit Avenue		STREET ADDRESS (If rural give location) 10325 Summit Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) George JOHNSON		4. DATE (Month) (Day) (Year) OF DEATH: July 9 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Feb. 21, 1876
9. AGE last birthday 79 yrs.		10. BIRTHPLACE (State or foreign country): Buck Lodge, Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Johnson		14. MOTHER'S MAIDEN NAME: Katherine Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No 3 (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-7898	
17. INFORMANT & ADDRESS: Mrs. Alta Johnson-Same Item #2			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 177X Acute myocardial failure		36 hours	
ANTECEDENT CAUSE (S) (B) Hypertensive heart disease		10 years?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Carcinoma of prostate		3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 19, 1954 , to July 9, 19 55 that I last saw the deceased alive on July 9, 19 55 , and that death occurred at 5:00 P. M, from the causes and on the date stated above.			
SIGNATURE Thomas A. Henderson		ADDRESS M. D. 3935 Balto. St. Kens. Md.	
DATE SIGNED 7/9/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/12/1955	
NAME OF CEMETERY OR CREMATORY St. John's		LOCATION (City, town, or county) (State) Forest Glen, Montg. Md.	
DATE REC'D BY LOCAL REGISTRAR 7-12-55		REGISTRAR'S SIGNATURE Bessie M. Thompson	
FUNERAL DIRECTOR W. A. Humphrey		ADDRESS Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 - 10 - 53

MARGIN RESERVED FOR BINDING

1

M

X
X

RECEIVED
JUL 18 1955
BUREAU V. 1

6866

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>Bethesda</u>		<u>235 days</u>		<u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Clinical Center</u>				<u>1724 - 17th St. N.W.</u>			
50							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Jan Karszo-Siedlewski</u>				<u>July 8 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>M</u>		<u>W</u>		<u>Married</u>		<u>December 1, 1891</u>	
						9. AGE last birthday	
						<u>63</u> yrs.	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Translator</u>		<u>Federal Government</u>		<u>Poland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wlodyslaw Karszo-Siedlewski</u>				<u>Aniela Gradzinow</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>Not stated</u>		<u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>205X</u> <u>Mycosis fungoides involving skin, lymph nodes, liver and lungs</u>							
ANTECEDENT CAUSE (B) <u>205X</u> <u>nodes, liver and lungs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>-- 2</u>				<u>--</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<u>-- M.</u>				<u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		<u>--</u>	
22. I hereby certify that I attended the deceased from Nov. 15, 1954, to July 8, 1955, that I last saw the deceased alive on July 8, 1955, and that death occurred at 8:30AM, from the causes and on the date stated above.							
SIGNATURE <u>Eugene J. Van Scott</u>				ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>July 8, 1955</u>	
23. BURIAL, CREMATION, DATE THEREOF				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>July 11 - 1955</u>				<u>Cedar Hill Cem.</u>		<u>Smithland MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/9/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Martin W. Hyman c 1300 N St</u>	

PLEASE TYPE IN WRITING PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 13 1955

RECEIVED

6867

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>5520 Johnson Avenue</u>	
3. NAME OF DECEASED: (First) <u>EDWARD</u> (Middle) <u>F.</u> (Last) <u>KEATING</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 11, 1878</u>
9. AGE last birthday: <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Property guard</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u></u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Edward T. Keating</u>		14. MOTHER'S MAIDEN NAME: <u>Hanora Lonergan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Thomas Quigley</u> <u>Sister- 5520 Johnson Ave. Bethesda Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Pneumonia</u>			<u>2 days</u>
ANTECEDENT CAUSE (S) (B) <u>Coronary heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>July 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>8:45 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dr. Joseph Henrich</u>		ADDRESS <u>M. D. 6450 Wisconsin Ave, Bethesda Md.</u>	
DATE SIGNED <u>7/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Specific</u>		DATE THEREOF <u>8-3-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cath Cem.</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

AUG 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6869
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06853

Reg. Dist.

No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montg</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Montg.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Silver Spring</u>	LENGTH OF STAY (In this place) <u>7 mo</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>602 East Ave</u>		STREET ADDRESS (If rural, give location) <u>602 East Ave</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Zacharias</u>	(Middle)	(Last) <u>Kepalos</u>	(Month) <u>7</u> (Day) <u>-18</u> (Year) <u>1951</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>11-25-12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>Restaurant</u>	9. AGE last birthday: <u>42</u> yrs.
13. FATHER'S NAME: <u>James Kepalos</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Pappas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Angela Kepalos (wife)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Cormery occlusion</u> DUE TO		<u>moder</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brossant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-18-51</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-22-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Arl. Nat. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>7-17-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
24. FUNERAL DIRECTOR <u>The S. N. Hines Co.</u>		ADDRESS <u>2901-14th St N.W. Washington 9 D.C.</u>	

BUREAU V. 1

JUL 21 1934

RECEIVED

6781

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>Takoma Park</u>		3 days		OR TOWN <u>washington</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <u>washington San. Hosp.</u>				7049 31st St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Catharine Elizabeth Keller				OF DEATH: July 28 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Fe	Cauc	married	Nov. 6, 1881	73 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
10A. <u>Housewife</u>				10B. <u>Own home</u>		11. <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY?				12. <u>USA</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John T. Acker				Mary Neff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				17. INFORMANT & ADDRESS:			
				Hosp. Records			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
541.1 IMMEDIATE CAUSE				(A) Peritonitis			
ANTECEDENT CAUSE (S)				(B) Perforated duodenal ulcer			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(C) Rheumatoid arthritis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Chronic pulmonary edema			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 1952 to 7/28, 1955, that I last saw the deceased alive on 7/28, 1955, and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
J. F. Hubadeau				M. D. Schaefer Spring, Md.			
DATE SIGNED				DATE SIGNED			
7/28/55				7/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
Burial				Ft. Lincoln Cemetery, Bladensburg Rd. Pr. Geo. Co. Md.			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
July 28 1955				J. Wilson Dodd			
24. FUNERAL DIRECTOR				ADDRESS			
James D. Phillips				254 CARROLL ST. N.W. Takoma Park, D.C.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

COUNTY

Montgomery Co

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X TOWN Rural Damascus Md

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

KATHLEEN

KATHERINE

KIDWILL

4. DATE OF DEATH:

(Month)

(Day)

(Year)

July

18

1955

5. SEX:

5. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause

(a) Anteroselectic cardiovascular disease

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

10 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from April 25, 1955, to July 18, 1955, that I last saw the deceased

alive on July 12, 1955, and that death occurred at 4:00 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

JUL 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06856

6793

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: <u>Rockville</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>212 Horners Lane</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Robert</u> (Last) <u>Kinder</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 26</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>5/1/1919</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Common Helper Wash. Term. Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harvey Brooks Kinder</u>				14. MOTHER'S M maiden NAME: <u>Margaret Ellen Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>Vibla Kinder (Wife)</u> <u>212 Horners Lane, Rockville</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchogenic Carcinoma</u>						<u>2 yrs 9 mos</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11/18/52</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bronchogenic Carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 11, 1955</u> to <u>July 26, 1955</u> ; that I last saw the deceased alive on <u>July 26, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. B. Bowditch Hunter</u>				ADDRESS <u>M. D. 509 W. Mill Rd. Rockville, Md.</u>		DATE SIGNED <u>July 26, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Lamell H. Bagley</u>		24. FUNERAL DIRECTOR <u>Robert A. Cunningham</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU VI 8

JUL 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06857

6870

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Wheaton City TOWN Wheaton City HOSPITAL OR INSTITUTION OR STREET ADDRESS 4507 Adrian Street		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wheaton City STREET ADDRESS (If rural give location) 4507 Adrian Street	
3. NAME OF DECEASED: (Type or Print) Michael Joseph Kohan		4. DATE (Month) (Day) (Year) OF DEATH: July 1 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Aug. 25, 1895
9. AGE last birthday 59 yrs.		10. BIRTHPLACE (State or foreign country): Pennsylvania	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joseph Kohan		14. MOTHER'S MAIDEN NAME: Julia Havacs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. _____	
17. INFORMANT & ADDRESS: William Kohan - 4507 Adrian Street, Wheaton City, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 150X IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) Cancer of the esophagus DUE TO (B) metastatic cancer DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: Apr. 19th 55		19B. MAJOR FINDINGS OF OPERATION: Inoperable cancer of the esophagus, metastatic in the lung	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5:47 p.m., 1955 , to 1:47 p.m., 1955 , that I last saw the deceased alive on 30th June, 1955 , and that death occurred at 2:50 A.M. from the causes and on the date stated above. SIGNATURE G. H. Rauber, M.D. ADDRESS 1503 Good Hope Rd. S.E. DATE SIGNED July 1st 55 M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 5, 1955	
NAME OF CEMETERY OR CREMATORY Fort Lincoln		LOCATION (City, town, or county) (State) Prince George Co. Md.	
DATE REC'D BY LOCAL REGISTRAR 7-5-55		REGISTRAR'S SIGNATURE Charles Potter	
24. FUNERAL DIRECTOR W. W. Chambers Co.-Riverdale, Md.		ADDRESS	

RECEIVED

JUL 8 1965

BUREAU V. S.

6871

Item 14, Film 186 9-8-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 217

06858

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Olney</u>		<u>29 days</u>		TOWN <u>Brookeville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>July 4 1955</u>			
<u>William Lawrence</u>							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>colored</u>	<u>widowed</u>	<u>9/30/84</u>	<u>70</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lawrence</u>				<u>Mary Greenwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9</u>						<u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Apoplexy, Thrombotic</u>							
ANTECEDENT CAUSE (S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>55</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Bryant</u>				ADDRESS <u>Smiley Spuy, Md</u>		DATE SIGNED <u>9/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>7-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Valley Lee</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snodden</u>				LOCATION (City, town or county) (State) <u>St. Mary's County, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-7-55</u>				REGISTRAR'S SIGNATURE <u>Berinda B. Lowry</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

101 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06859

6872

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u> Rural		3 hr. 8 min		TOWN <u>Washington, D.C.</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1738 Corcoran Street, N.W.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Ba by Boy LETHRIDGE</u>				DATE OF DEATH: <u>July 13 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>Negroid</u>		<u>Single</u>		<u>7-13-55</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William LETHRIDGE</u>				<u>Colleen Delores SPICER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Mother Colleen D. LETHRIDGE Same as above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Immaturity</u>							<u>3 hr. 8 min</u>
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 July, 1955</u> , to <u>13 July, 19 55</u> , that I last saw the deceased alive on <u>13 July, 1955</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. L. S. BAIRD LTJG (MC) USNR</u>				ADDRESS		DATE SIGNED	
<u>R. L. S. BAIRD LTJG, MC, USN</u>				<u>U. S. Naval Hospital, NNMC, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>19 July 1955</u>		<u>Woodlawn Cemetery</u>		<u>Montgomery Co, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-14-55</u>		<u>Harry E. Carrelly</u>		<u>Hall Brothers Funeral Home</u>		<u>621 Florida Ave., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

2075251200

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6873

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06860

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>10 hours</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural, give location) <u>11708 Newport Mill Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Irene Kempie Logan</u>				<u>July 6 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Widow</u>		<u>Sept 1, 1881</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work, life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>73 yrs.</u>		<u>Housewife</u>		<u>Tennessee</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Daughter, Mary Minogue - above</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>450.0</u> Immediate cause (a) <u>Congestive Heart failure</u> DUE TO Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchial pneumonia</u> <u>Arterial arteriosclerosis</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH	
				<u>Potomac Montg Md</u>		<u>7 months</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 2, 1955 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell on floor of her room</u>		<u>7 yrs.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-7-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>8 July 55</u>		<u>Cedar Hill Cemetery</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>7/7/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Thomas J. Collins</u>		3821-14 ADDRESS <u>Wash., D.C.</u>	

BUREAU V. S.

JUL 11 1955

RECEIVED

6874

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>56 Silver Spring, Md</i>	LENGTH OF STAY (in this place) <i>10 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>56 Silver Spring, Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 1114 Woodside Parkway Silver Spring, Md</i>		STREET ADDRESS (If rural give location) <i>1114 Woodside Parkway Silver Spring, Md</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>Lawrence Bertrand Maloney</i>		<i>July 10 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>M</i>	8. DATE OF BIRTH: <i>March 28, 1903</i>
		9. AGE last birthday <i>52 yrs</i>	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>owner</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Hardware</i>	11. BIRTHPLACE (State or foreign country): <i>Dayton, Md</i>
13. FATHER'S NAME: <i>Thomas Maloney</i>		14. MOTHER'S MAIDEN NAME: <i>Susan Hill</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>3 NO</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>012-07-2169</i>	
17. INFORMANT & ADDRESS: <i>Wife - 1114 Woodside Parkway</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <i>162X</i>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Pulmonary edema</i>			<i>3 hrs.</i>
(B) <i>lung abscess</i>			<i>3 weeks</i>
(C) <i>Bronchogenic carcinoma</i>			<i>10 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>Oct 54</i>		19B. MAJOR FINDINGS OF OPERATION: <i>no Bronchogenic carcinoma</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April</i> , 1955, to <i>July 10</i> , 1955, that I last saw the deceased alive on <i>July 10, 1955</i> , and that death occurred at <i>6:05 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Ralph P. Tatten MD</i>		ADDRESS <i>8641 Colverville Rd Silver Spring, Md</i>	
DATE SIGNED <i>July 10, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7-13-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Mt Olivet</i>		LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 14, 1955</i>		REGISTRAR'S SIGNATURE <i>Frances Cotton</i>	
24. FUNERAL DIRECTOR <i>Emmett E. Garrison, Faithsburg, Md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

18 1955

RECEIVED

6875

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>26 days</u>		TOWN <u>Alexandria</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>1317 Abingdon Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>David</u> <u>MORGAN</u> <u>Matthews</u>				OF DEATH: <u>July</u> <u>23</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>September 29, 1904</u>	<u>50</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>RETIRED</u>				<u>SUPERVISOR, U.S. Govt</u>		<u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>David Matthews</u>				<u>Delia Friel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>not available</u>		<u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>BILATERAL TENSION PNEUMOTHORAX</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>PULMONARY EMPHYSEMA</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Cor PULMONALE</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
<input type="checkbox"/>		<u>NONE</u>					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 June, 1955</u> , to <u>23 July, 1955</u> , that I last saw the deceased alive on <u>23 July, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Eugene Braunwald</u>		<u>The Clinical Center</u> <u>National Institutes of Health</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-25-55</u>		<u>CALVARY CEMETERY</u>		<u>CLEVELAND, OHIO</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/28/55</u>		<u>Bessie M. Thompson</u>		<u>S. H. Jones Co.,</u>		<u>Washington, DC</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06863

6876

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Olney</u>		<u>16 days</u>		TOWN <u>Sandy Spring</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Montgomery County General Hospital, Inc</u>		STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Elizabeth Olivia Matthews</u>				OF DEATH: <u>July 3 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Colored</u>	<u>Separated</u>	<u>2/23/12</u>	<u>43</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Walter Matthews</u>				<u>Bessie Newman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u> (If Yes, give war or dates of service)				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Adenocarcinoma of colon</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>3/5/55</u>		<u>Adenoma-Carcinoma of the cecum</u>					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. B. Bonnard</u>				M. D. <u>Sandy Spring Md</u> DATE SIGNED <u>7/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-6-55</u>		<u>Ash Memorial</u>		<u>Sandy Spring, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-8-55</u>		<u>Arthur B. Lawrence</u>		<u>Robert L. Snowden</u>		<u>Rockville</u>	

BUREAU V. S.

JUL 8 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6877 CERTIFICATE OF DEATH

068864
216

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Chevy Chase</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Chevy Chase</u>		TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Primrose St.</u>				STREET ADDRESS (If rural give location) <u>9 Primrose St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM ANDREW MEARNS</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>July 5 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-10-1870</u>	9. AGE last birthday: <u>85</u> yrs.	Months <u>5</u>	Days <u>20</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Banking</u>		11. BIRTHPLACE (State or foreign country): <u>Phila., Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Robert Kirkpatrick Mearns</u>			
14. MOTHER'S MAIDEN NAME: <u>Martha D. Poole</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>9 Primrose St. David C. Mearns, Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>334X</u> Immediate cause (a) <u>Cerebral arteriosclerosis</u> Antecedent causes (s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u> 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1954</u> to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. J. Oler, M.D.</u>		(Degree or title)		DATE SIGNED <u>July 4 '55</u>		ADDRESS <u>1150 Conn. Av. N.W. Wash. D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-7-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wash. DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Joseph Lawler Sons</u>		ADDRESS <u>1756 Pa. Ave. NW</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 8 1955

RECEIVED

6878

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>14 hr 46 min</u>		STREET ADDRESS (If rural give location) <u>3432 25th Street, S.E.</u>		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				57			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH: <u>July 31 19 55</u>	
<u>Gregory Lee MILLER</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>7-30-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Ivandale MILLER</u>				14. MOTHER'S MAIDEN NAME: <u>Sue Yvonne ALLISON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Father Ivandale MILLER Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myeloid membrane disease</u>						12 hrs	
ANTECEDENT CAUSE (S) DUE TO <u>Prematurity</u>						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>30 July, 1955</u> , to <u>31 July, 1955</u> , that I last saw the deceased alive on <u>31 July</u> , 19 <u>55</u> , and that death occurred at <u>12:45A</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Pearson</u>				ADDRESS		DATE SIGNED	
H. A. PEARSON LTJG MC USN U.S. Naval Hospital, NMMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4 Aug 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-31-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Garselly</u>		R. A. Pumphrey Funeral Home		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 2 1955

RECEIVED

6879

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Kensington</u>		<u>Since 9-10-54</u>		OR TOWN <u>Washington</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		IF rural give location			
<u>90 Kensington Gardens 3000</u>		<u>McComas Ave</u>		<u>4700 Haverport St. N.W.</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Oliver</u>		<u>B</u>		<u>Miller</u>			
4. DATE OF DEATH:		(Month)		(Day)		(Year)	
<u>7 - 16</u>		<u>1955</u>					
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>7</u>		<u>W</u>		<u>W</u>		<u>Dec-13-1881</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>73</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>CLERK</u>				<u>VA.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CHRISTOPHER W. CLASKETT</u>				<u>EMMA RAYNOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>NONE</u>		<u>REST HOME RECORDS</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
<u>442X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>congestive heart failure</u>						<u>1 wk.</u>	
(B) <u>cardio-vascular-renal disease</u>						<u>7 yrs.</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Parkinson's Disease</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
20. AUTOPSY?							
YES <input type="checkbox"/>		NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 9, 1953</u> , to <u>July 16, 1955</u> , that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Sidney Choussier</u>		<u>M. D. 3921 Ingomar St. N.W. Wash. D.C.</u>		<u>7/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-18-55</u>		<u>Bluemood Centry</u>		<u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-16-55</u>		<u>Bessie M. Thompson</u>		<u>Cherry Chase Funeral Home</u>		<u>5705 Wisconsin Ave. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

JUL 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6880

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06867

Item 9, Film G185 8-30-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

See: Item 17

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		TOWN	
X TOWN <u>Bethesda</u>				STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Suburban Hospital</u>		<u>8801 Montgomery Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Michael J. Moses</u>				<u>July 18, 1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>9/28/12</u>	
				9. AGE last birthday: <u>43</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Restaurant</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>John Moses</u>				14. MOTHER'S MAIDEN NAME: <u>Rathade</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL RESERVE? (Yes, no, or unk.): <u>9</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Mary Moses - wife</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>				(A) <u>Constrictive heart failure</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Hypertensive heart disease</u>			
				DUE TO			
				(C) <u>Essential hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Embolus of popliteal artery</u>							
19A. DATE OF OPERATION: <u>7-17-55</u>				19B. MAJOR FINDINGS OF OPERATION: <u>A popliteal embolectomy</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-6, 1955</u> , to <u>7-18, 1955</u> , that I last saw the deceased alive on <u>7-18, 1955</u> , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joan Leiger</u>				ADDRESS <u>931 Peaching Drive</u>		DATE SIGNED <u>7-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>7-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parblawn Ind. Parkville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W.M. Chambers</u>	
				ADDRESS <u>6-1400-Thapin St.</u>			

RECEIVED

JUL 25 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6881
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06868

Reg. Dist.

No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7213 Oakridge Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u> STREET ADDRESS (If rural, give location) <u>7213 Oakridge Ave.,</u>	
3. NAME OF DECEASED: (Type or Print) <u>James</u> (First) <u>Edward</u> (Middle) <u>Mulligan</u> (Last) 4. DATE OF DEATH <u>July 22</u> 19 <u>55</u>		5. SEX: <u>Male</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> 8. DATE OF BIRTH: <u>Sept. 7, 1901</u> 9. AGE last birthday: <u>53</u> yrs. <u>5</u> mos. <u>15</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Research Anal.</u> 10b. KIND OF BUSINESS OR INDUSTRY: <u>John's Hopkins Hosp.</u> 11. BIRTHPLACE (State or foreign country): <u>Augusta, Maine.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>James E. Mulligan</u> 14. MOTHER'S MAIDEN NAME: <u>Elizabeth McCormick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: <u>420-1</u> 17. INFORMANT & ADDRESS: <u>Mara Elizabeth Mulligan</u> wife- <u>Same as item #2.</u>		18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420-1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Sudden</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: <u>7-23-55</u> 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY 21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Dr. J. B. Burchart</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-23-55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Transit-burial</u> DATE THEREOF <u>7-23-55</u> NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u> LOCATION (City, town, or county) (State) <u>Lincoln County, Maine</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-23-55</u> REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

JUL 26 1955

BUREAU V. 3

6882

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 23 days		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center				STREET ADDRESS (If rural give location) 10205 Proctor St.			
3. NAME OF DECEASED: (First) (Middle) (Last) Kinhead Worthington Munsch				4. DATE (Month) (Day) (Year) OF DEATH: July 13 1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 17 August 1895	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife - Clerk-		10B. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. Naval Ordnance		11. BIRTHPLACE (State or foreign country): Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Samuel Worthington				14. MOTHER'S MAIDEN NAME: Sallie Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None given		17. INFORMANT & ADDRESS: The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
150X							
IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Confluent bronchopneumonia in a patient with recurrent carcinoma of the esophagus							
DUE TO							
(B) Metastatic carcinoma in liver & multiple abdominal, thoracic & cervical lymph nodes							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
None		None		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 20, 1955 to July 13, 1955 that I last saw the deceased alive on July 13, 1955 , and that death occurred at 8:40AM , from the causes and on the date stated above.							
SIGNATURE Bernard Robert Landau				ADDRESS M.D. The Clinical Center, NIH		DATE SIGNED July 13, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Trans. & Burial		DATE THEREOF 7/14/55		NAME OF CEMETERY OR CREMATORY Versailles Cemetery		LOCATION (City, town, or county) (State) Versailles, Woodford Co., Ky.	
DATE REC'D BY LOCAL REGISTRAR 7-13-55		REGISTRAR'S SIGNATURE Bessie M. Hampson		24. FUNERAL DIRECTOR Walter E. Pumphrey		ADDRESS 8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

NOTE

BUREAU VI 81

JUL 18 1955

ED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06870

6883

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Bethesda</u> <u>Rural</u>		<u>2 months</u>		<u>Bethesda</u> <u>Rural</u> <u>Arlington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS <u>1007 N. Jefferson St.</u> (If rural give location) <u>U. S. Naval Hospital (see birth c.)</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
<u>Virginia</u> <u>(N)</u> <u>NEIL</u>		<u>July</u> <u>5</u> <u>1955</u>		<u>Female</u>		<u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:		9. AGE last birthday		IF UNDER 1 YEAR	
<u>Single</u>		<u>4-28-55</u>		<u>2</u> yrs.		<u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Spencer NEIL</u>				<u>Anne C. WALSH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>None</u>		<u>Father John S. NEIL</u> <u>3910 Ave. 7th, Brooklyn, New York</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia, Terminal</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Multiple Congenital Abnormalities, 2 Meningo-Myelocele open & closed and microcephaly</u>						<u>2 Mo's</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>7 days</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>2</u>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 April, 1955</u> , to <u>5 July, 1955</u> , that I last saw the deceased alive on <u>5 July, 1955</u> , and that death occurred at <u>0705A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				ADDRESS <u>U. S. Naval Hospital NMHC Bethesda Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-9-55</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-5-55</u>		<u>Mary E. Savelly</u>		<u>R. A. Pumphrey Funeral Home, 7557 Wisc., Avenue, Bethesda, Maryland</u>			

BUREAU V. S.

JUL 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06871

6884

CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	TOWN <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>74 Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5124 Bradley Blvd</u>	
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>V.</u> (Last) <u>Newkirk</u>		4. DATE (Month) <u>July</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>10/19/76</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>18</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<u>Ohio</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Tobias Hughes</u>		14. MOTHER'S MAIDEN NAME: <u>Florence Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Francis M. Newkirk-Item # 2</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>4221 intestinal hemorrhage</u>			
ANTECEDENT CAUSE (S) DUE TO <u>cause unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>myocarditis, generalised</u>			
STATING UNDERLYING CAUSE LAST. (C) <u>decalcification, extreme, of lumbar spine</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 7/7/55</u> , 19 <u>54</u> , to <u>7/7/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/6/55</u> , 19 <u>55</u> , and that death occurred at <u>12.50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Philip Bloemendaal</u>		DATE SIGNED <u>7-7-55</u>	
M.D. <u>5911 16th St. NW. Wash., D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED
JUL 18 1955
BUREAU V. 2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				06872	
CERTIFICATE OF DEATH				Reg. Dist. No. 216	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	MONTGOMERY		STATE	MD.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	BETHESDA	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	SUBURBAN HOSPITAL		STREET ADDRESS	5607 LINCOLN STREET	
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
JOHN WILLIAM NOREIS			JULY 3 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
M	W	WIDOWED	DEC. 27, 1881	73 yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
ENGINEER		RAILROAD	MARYLAND	U.S.A.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
BENJAMIN FRANKLIN NOREIS			ANN LOUISE PETERS		
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk. If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS:		
			MRS. GERTRUDE FUNK — 5607 LINCOLN BETHESDA, MD.		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
420.1					
IMMEDIATE CAUSE					
(A) ACUTE MYOCARDIAL INFARCTION					6 days
ANTECEDENT CAUSE (B):					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(B) ACUTE CORONARY THROMBOSIS					6 days
(C) ARTERIO SCLEROSIS					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
			21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 6-27, 1955, to 7-3, 1955, that I last saw the deceased alive on 7-3, 1955, and that death occurred at 11:30 M, from the causes and on the date stated above.					
SIGNATURE			DATE SIGNED		
D. J. Brennan			7-3-55		
M. D.			Bethesda, Md.		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
Burial		7-6-55	Mt. Hebron Cem.		Frederick Co., Maryland
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
7/4/55		Beauregard Thompson		Robert R. Humphrey, Bethesda, Md.	

BUREAU V. S.

JUL 6 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

6782

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Takoma Park</u>		<u>1 day</u>		OR TOWN <u>Washington</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>75 Washington San. Hosp.</u>				<u>6219 8th St. N.W.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Walter Allan Osbourn</u>				OF DEATH: <u>July 4 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>Cauc</u>	<u>married</u>	<u>4-14-1884</u>	<u>71</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired R.R. mail Service Emp.</u>				<u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Osbourn</u>				<u>Alice Link</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>						<u>Hosp Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE						<u>36 hrs.</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>Acute myocardial infarction</u>							
(B) <u>Coronary atherosclerosis</u>						<u>3 yrs.</u>	
(C) <u>Hypertensive cardiovascular disease</u>						<u>3 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 3</u> , 19 <u>55</u> , to <u>July 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>55</u> , and that death occurred at <u>10²⁰</u> AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Bennet A. Porter, Jr., M.D.</u>				<u>M.D. 9301 Colesville Rd, Silver Spring, Md.</u>		<u>July 4, 55</u>	
23. BURIAL, CREMATION, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Interment</u>		<u>7-6-55</u>		<u>Springwood Cem.</u>		<u>Shepherdstown W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 4-1955</u>		<u>John R. Dadd</u>		<u>Real Funeral Home</u>		<u>4812 1/2 Ave NW Wash</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 2 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06874
6886
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY <u>56</u> If outside corporate limits, write RURAL OR and give nearest town		LENGTH OF STAY <u>19</u> years (in this place)		CITY <u>56</u> If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>816 Gist Ave.</u>				STREET ADDRESS (If rural give location) <u>816 Gist Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>FRANK G. PALEOLOGOS</u>				<u>July 22 - 19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Nov. 28, 1891</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Resturant Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>None-exiled</u> ✓	
13. FATHER'S NAME: <u>George Paleologos</u>				14. MOTHER'S MAIDEN NAME: <u>Chrysa Kahris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-unavailable</u>		17. INFORMANT & ADDRESS: <u>Mrs. Despina Paleologos</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>few minutes</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary thrombosis</u>						<u>31 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary artery arteriosclerosis</u>						<u>31 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 29, 1957</u> , to <u>July 22, 1955</u> , that I last saw the deceased alive on <u>July 21</u> , 1955, and that death occurred at <u>2:45p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ramon H. Traim</u>		ADDRESS <u>M. D. 8231 Georgia Ave - Silver Spring Md</u>		DATE SIGNED <u>July 23 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Walter C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

JUL 27 1955

RECEIVED

6783

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	LENGTH OF STAY (in this place) 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Washington Sanitarium & Hospital		STREET ADDRESS (If rural, give location) 816 Gist Ave.	1
3. NAME OF DECEASED: (First) (Middle) (Last) Elias George Palogos (Paleologos)		4. DATE (Month) (Day) (Year) OF DEATH: 7-8-1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: 3-15-95
9. AGE last birthday 60 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): owner		10B. KIND OF BUSINESS OR INDUSTRY: Restaurant	
11. BIRTHPLACE (State or foreign country): Greece		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME: George Palogos (Paleologos)		14. MOTHER'S MAIDEN NAME: Chrissy Kachris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) Yes (unavailable)	
17. INFORMANT & ADDRESS: Hospital Record			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 420.1			8 days
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			8 days
(A) Massive infarct myocardium			
(B) Coronary artery thrombosis			Unknown
(C) Coronary arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 30, 1955 , to July 8, 1955 , that I last saw the deceased alive on July 8, 1955 , and that death occurred at 2:43 PM , from the causes and on the date stated above.			
SIGNATURE Caron H. Trauer		ADDRESS M. D. 8237 Georgia Ave Silver Spring Md July 8 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/11/55	
NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		LOCATION (City, town, or county) (State) Washington, D. C.	
DATE REC'D BY LOCAL REGISTRAR July 10 1955		REGISTRAR'S SIGNATURE William D. Cold	
24. FUNERAL DIRECTOR Warner E. Humphrey		ADDRESS 8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

JUL 13 1955

BUREAU V. 3.

RECEIVED

6887

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
X TOWN <u>Olney</u>	<u>2 1/2</u> days	TOWN <u>Marriottsville</u> <u>13X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Rebekah</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Paul</u>	(Month) <u>July</u> (Day) <u>4</u> (Year) <u>19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/16/73</u>
9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Arthur McLean</u>		14. MOTHER'S MAIDEN NAME: <u>Ruth Hobbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk -</u>		16. SOCIAL SECURITY No. <u>unk -</u>	
17. INFORMANT & ADDRESS: <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute cardiac failure</u>		<u>17 hours</u>
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic heart disease</u>		<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Carcinoma uterus with metastasis to rectum causing acute intestinal obstruction.</u>		<u>1 week</u>
--	--	---------------

19A. DATE OF OPERATION: <u> </u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from <u>July</u>, 19 <u>47</u> to <u>July</u>4, 19 <u>55</u> that I last saw the deceased alive on <u>July 3</u> , 19 <u>55</u> , and that death occurred at <u>6:15</u> am, from the causes and on the date stated above.	
SIGNATURE <u>Charles S. Whitaker</u>	DATE SIGNED <u>7/4/55</u>

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt View</u>	LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>
---	----------------------------	--	---

DATE REC'D BY LOCAL REGISTRAR <u>July 5, 1955</u>	REGISTRAR'S SIGNATURE <u>Estelle B. Lawler</u>	24. FUNERAL DIRECTOR <u>Ruth A. Houghton</u>	ADDRESS <u>Glynnville, Md.</u>
---	--	--	--------------------------------

MARGIN RESERVED FOR BINDING

A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAR 14 1955

RECEIVED

6888

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) BETHESDA
 TOWN BETHESDA
 HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY MONTGOMERY
 CITY (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE
 OR TOWN ROCKVILLE
 STREET ADDRESS (If rural give location) 806 GRANDIN AVENUE

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

LAURAEPETERS

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JULY 151955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FEMALE WHITEWHITESINGLEDECEMBER 17, 187282 yrs.6 Months28 Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

9040

IMMEDIATE CAUSE

(A)

Antero-Septic Heart Disease

DUE TO

ANTECEDENT CAUSE (S)

(B)

Fracture Left Femur

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

1 month

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Melanin & Infection

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

6/15/55Fracture Left FemurYES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work Not while at work

21F. HOW DID INJURY OCCUR?

6/12/559³⁰ A. M.At Fall in Home22. I hereby certify that I attended the deceased from 6/13, 1955, to 7/5, 1955, that I last saw the deceasedalive on 7/5, 1955, and that death occurred at 6⁰⁰ P. M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Clinton B. Rohrbach

M. D.

104 Chevy Chase, Ch. Md.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-20-55Bessie M. ThompsonRobert A. HumphreyBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAR 22 1955

RECEIVED

6889

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Kensington</u>		LENGTH OF STAY (in this place) <u>4 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>3406 Cummings Lane</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Carroll Hall Sanatorium 10231 Carroll Place</u>				STREET ADDRESS (If rural give location) <u>Chevy Chase 15, Md</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Andretta Wreath Phyfe</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 22 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>24 Nov 1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York, NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Andrew Wreath</u>				14. MOTHER'S MAIDEN NAME: <u>Mary McGonigle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Herbert L. Phyfe 3406 Cummings Ln, Chevy Chase 15, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>332X cerebral thrombosis</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>cerebral arteriosclerosis</u>						<u>X years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arterio sclerosis</u>						<u>X years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 July 1955</u> , to <u>20 July 1955</u> that I last saw the deceased alive on <u>20 July 1955</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Luchs</u>		DATE SIGNED <u>22 July</u>		ADDRESS <u>2700 Wisconsin NW</u>		1-23-1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>KENSICO CEM.</u>		LOCATION (City, town, or county) <u>WESTCHESTER CO. N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Joseph Charles Sora 1124 Sch. St.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Broschart Notified - has approved
per Mr. Lucke 1:10^{PM} 7-23-55

BUREAU V. S.

AUG 1 1955

RECEIVED

6890

CERTIFICATE OF DEATH

Reg. Dist. No. 214.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>North Carolina</u> COUNTY <u>Forsyth</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	LENGTH OF STAY (in this place) <u>2 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winston Salem</u>	<u>70X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 Schuyler Rd.</u>		STREET ADDRESS (If rural give location) <u>936 No. Hawthorne Rd.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mary</u> (Middle) <u>B</u> (Last) <u>Piper</u>		DATE OF DEATH: <u>July 17, 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Jan 7, 1883</u>
		9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homf.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Albert M. Bounds</u>		14. MOTHER'S MAIDEN NAME: <u>Clara Cordelia Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Alexander Piper, Winston Salem, NC</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>334X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cerebrovascular, general & cerebral</u>			<u>1 year</u>
DUE TO			
(B)			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatic heart disease</u>			<u>Years</u>
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 13, 1955</u> , to <u>July 17, 1955</u> , that I last saw the deceased alive on <u>June 21, 1955</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Severy Leventhal</u>		ADDRESS <u>M.D. Silver Spring, Md.</u>	DATE SIGNED <u>July 17, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>July 20, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>	REGISTRAR'S SIGNATURE <u>James G. Gatter</u>	24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>	ADDRESS <u>Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 21 1955

RECEIVED

6784

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Missouri</u>	COUNTY <u>St. Louis</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17</u> TOWN <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>10</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vinata Park</u>	<u>62x3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75</u> Washington Sanitarium & Hospital		STREET ADDRESS (If rural give location) <u>8211 Washington St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>CHARLES EDWARD POLLAK</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 24</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Dec. 1, 1869</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired - Wholesale Milliner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Louisiana, Mo.</u>	
13. FATHER'S NAME: <u>William Pollak</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Dvorak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-unavailable</u>	
17. INFORMANT & ADDRESS: <u>Silver Spring, Md.</u>		17. INFORMANT & ADDRESS: <u>Edw. Chas. Pollak, 207 Lexington Drive,</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive cardiac failure</u>			<u>12 hrs</u>
ANTECEDENT CAUSE (S) (B) <u>Severe post-tricus coronary thrombosis</u>			<u>10 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>with infarction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1955</u> , to <u>July 24, 1955</u> that I last saw the deceased alive on <u>July 24, 1955</u> , and that death occurred at <u>12:10 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Emmett E. Harmon</u>		DATE SIGNED <u>July 24, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 24, 1955</u>	
NAME OF CEMETERY OR CREMATOR <u>Bell Fountain Cemetery</u>		LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-24-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Walter E. Rumpel, Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 26 1955

RECEIVED

6891
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Monig.</i> MARYLAND			STATE <i>MD.</i> COUNTY <i>Montg.</i>		
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Olney</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Burtonsville, Md - X</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Monig. Co. Gen. Hosp.</i>			STREET ADDRESS (If rural, give location) <i>Spencerville</i>		
3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year) OF DEATH:		
(First) (Middle) (Last) <i>Poole Maggie Amelia</i>			<i>7 24 1955</i>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days
<i>f</i>	<i>w</i>	<i>WIDOWED</i>	<i>6.30 - 70</i>	<i>85</i> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>Same</i>	11. BIRTHPLACE (State or foreign country): <i>Spencerville Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME: <i>Louis Duval</i>			14. MOTHER'S MAIDEN NAME: <i>Mary Jane Spencer</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
<i>9</i>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Apoplexy, thrombotic</i>		<i>6 months</i>
ANTECEDENT CAUSE (S) (B) <i>Chronic myocarditis</i>		<i>10 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>0</i>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/3*, 19*55*, to *7/24*, 19*55*, that I last saw the deceased alive on *7/24*, 19*55*, and that death occurred at *M.*, from the causes and on the date stated above.

SIGNATURE <i>D. D. Brignaut</i>	ADDRESS <i>Sandy Spring Md.</i>	DATE SIGNED <i>7/24</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>July 26-55</i>	NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>
LOCATION (City, town, or county) (State) <i>Burtonsville Md.</i>	24. FUNERAL DIRECTOR <i>Walter Donaldson</i>	ADDRESS <i>Spencerville Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>July 26 - 55</i>	REGISTRAR'S SIGNATURE <i>Gertrude B. Fowler</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1955

BUREAU V. S.

6892

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Olney	COUNTY	Montgomery
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Montgomery County General Hospital, Inc	STREET ADDRESS	
LENGTH OF STAY (in this place)	2 days	(If rural give location)	

3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE (Month) (Day) (Year)
(Type or Print)	Annie	Virginia	Pope	OF DEATH: July 13 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female	White	Married	7/31/1873	81 yrs.	Months	Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Rufus Stevens	Mary Kenney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
(If Yes, give war or dates of service)		Hospital Record

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) DUE TO	3 days
ANTECEDENT CAUSE (S)	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from July 11, 1955, to July 13, 1955, that I last saw the deceased alive on July 13, 1955, and that death occurred at 4:12 PM, from the causes and on the date stated above.

SIGNATURE	DATE SIGNED		
John Schumacher	July 13, 1955		
M. D.	Baltimore, Md.		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-15-55	Woodfield	Woodfield Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 14, 1955	Gertrude B. Lawler	Edmund C. Galtner	Gaithersburg Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 22 1955

RECEIVED

6893

06883

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Silver Spring</u>		<u>4 yrs</u>		TOWN <u>Silver Spring</u>		<u>5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8902 Manchester Rd</u>				STREET ADDRESS (If rural, give location) <u>8902 Manchester Rd</u>			
3. NAME OF DECEASED: (First) <u>Sally</u> (Middle) <u>Peacock</u> (Last) <u>Potter</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 22, 1922</u>	
9. AGE last birthday: <u>32</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Detroit, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Marshall Peacock</u>				14. MOTHER'S MAIDEN NAME: <u>Rachel McLeod</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Yes</u>		17. INFORMANT & ADDRESS: <u>W. Taylor Potter, 8902 Manchester Rd., SS</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>970.2</u> Immediate cause (a) <u>Barbiturate poisoning</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							<u>From</u> <u>dead at</u> <u>home</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Was a mental case and had taken</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschard</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-17-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF <u>July 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

111 21 1005

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06884

6894

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		309 days		TOWN <u>Kensington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>10310 Greenfield St.</u>			
3. NAME OF DECEASED: (First) <u>George</u>		(Middle) <u>A.</u>		(Last) <u>Powers</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 27, 1905</u>		9. AGE last birthday <u>50</u> yrs.		IF UNDER 24 HRS. Months <u>0</u> Days <u>2</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Music teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Teaching</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George E. Powers</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Macdonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>031-12-4108</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
430.0 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Subacute Bacteria Endocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B)							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of the Stomach</u>							
19A. DATE OF OPERATION: <u>12/6/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Inoperable Carcinoma of the Stomach</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sep 23, 1954</u> , to <u>July 29, 1955</u> that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John L. Fahy</u>		ADDRESS <u>The Clinical Center</u>		M. D. <u>Nat'l Inst. of Health</u>		DATE SIGNED <u>7/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

AUG 3 1955

RECEIVED

06885

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write <i>RURAL</i> and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write <i>RURAL</i> and give nearest town)		OR TOWN	
17 TOWN <i>Takoma Park</i>		3 days		17 TOWN <i>Takoma Park</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
75 <i>Washington Sanitary Hospital</i>				113 Elm Ave			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
JOHN JAMES RAINES				DEATH: July 3 1955			
5. SEX: M		6. COLOR OR RACE: white		7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): M		8. DATE OF BIRTH: 8/25/1870	
				9. AGE last birthday: 83 yrs.		IF UNDER 1 YEAR: Months Days	
						IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>carpenter</i>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Virginia</i>	
13. FATHER'S NAME: <i>M. (name unknown) Raines</i>				14. MOTHER'S MAIDEN NAME: <i>Josephine (last name unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>Benjamin Raines 113 Elm Ave Takoma Park</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>							unknown
ANTECEDENT CAUSE (B) <i>Cerebra</i>							unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/1, 1955, to 7/3, 1955, that I last saw the deceased alive on 7/2, 1955, and that death occurred at 4 A. M. from the causes and on the date stated above.							
SIGNATURE <i>Benjamin Raines</i>				ADDRESS <i>M.D. 8901 University Lane S.S. Md.</i>		DATE SIGNED <i>7/3/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Removal</i>		7-3-55		<i>Washington D.C.</i>		<i>D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 2-1955		<i>J. Wilson Deter</i>		<i>Deer Funeral Home</i>		<i>4812 40 Ave NW Wash</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1955

BUREAU V. S.

6895

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montg.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10127 Cedar Lane</u>		STREET ADDRESS (If rural give location) <u>10127 Cedar Lane</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Anna</u>	(Middle)	(Last) <u>Rajacich</u>	(Month) <u>July</u> (Day) <u>14</u> (Year) <u>19 55</u>
5. SEX: <u>Female</u>		6. AGE last birthday: <u>78</u> yrs.	
7. COLOR OR RACE: <u>White</u>	8. DATE OF BIRTH: <u>Apr. 5 1877</u>	9. AGE last birthday: <u>78</u> yrs.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Yugoslavia</u>	
13. FATHER'S NAME: <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S. A.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Michael Rae -son</u>		18. MEDICAL CERTIFICATION	
19a. DATE OF OPERATION: <u>7/12/55</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Generalized Arteriosclerosis</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death <u>1 day</u>
2. MEDICAL CERTIFICATION		
3. MEDICAL CERTIFICATION		

11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY?	
Conditions contributing to the death but not related to the disease or condition causing death.		<u>Yes U.S. A.</u>	
19a. DATE OF OPERATION: <u>7/12/55</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Generalized Arteriosclerosis</u>	
20. AUTOPSY ?		21. ACCIDENT SUICIDE HOMICIDE	
Yes <input type="checkbox"/> No <input type="checkbox"/>		(Specify)	
22. I hereby certify that I attended the deceased from <u>7/12/55</u> , to <u>7/14/55</u> , that I last saw the deceased alive on <u>7/14/55</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (Specify)	
DATE RECD BY LOCAL REGISTRAR: <u>7-15-55</u>		DATE THEREOF: <u>7-15-55</u>	
REGISTRAR'S SIGNATURE: <u>Beacie M. Thompson</u>		NAME OF CEMETERY OR CREMATORY: <u>Calvary Cemetery</u>	
24. FUNERAL DIRECTOR		LOCATION (City, town, or county) (State)	
ADDRESS: <u>Bethesda, Md</u>		ADDRESS: <u>St. Louis Co. Minneapolis</u>	

RECEIVED
JUL 18 1955
BUREAU V. 3

6896

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montg.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Rural - Damascus</u> LENGTH OF STAY (in this place) <u>Years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Rural - Damascus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. Mt. Airy</u>				STREET ADDRESS (If rural give location) <u>R.F.D. Mt. Airy</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Mamie Elizabeth Ridgley</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>July 5 19 55</u>				
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 3, 1884</u>		9. AGE last birthday: <u>71</u> yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <u>Housewife - Own Home</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Benjamin Browning</u>				14. MOTHER'S MAIDEN NAME: <u>Lydia Lydard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>James D. Ridgley, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>156.1</u> Immediate cause (a) <u>Cancer of the liver</u> Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							<u>8 months</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1954</u> , to <u>July 5, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James P. Kern M.D.</u>				ADDRESS <u>Damascus, Md.</u>		DATE SIGNED <u>7/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Damascus</u>		LOCATION (City, town, or county) (State) <u>Damascus, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Della M. Burdette</u>		24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6897
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06888
Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <i>Cherry Chase</i>		<i>1 yr</i>		TOWN <i>Cherry Chase</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>8412 Farrell St</i>				STREET ADDRESS (If rural, give location) <i>8412 Farrell St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Max Ripkin</i>				<i>July 27 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>3-31-12</i>	9. AGE last birthday: <i>43</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Store clerk</i>				10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Abraham Ripkin</i>				14. MOTHER'S MAIDEN NAME: <i>Anna Decker</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Virginia Ripkin (wife) Same as above</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <i>Coronary occlusion</i> DUE TO						<i>Sudden</i>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <i>0</i>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>7-27-55</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>7/28/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Math. Mem. Park</i>		LOCATION (City, town, or county) (State): <i>Falls Church, Va</i>	
DATE REC'D BY LOCAL REG. <i>7-29-55</i>		REGISTRAR'S SIGNATURE: <i>Frances Potter</i>		24. FUNERAL DIRECTOR: <i>C.D. Goldberg</i>		ADDRESS: <i>1717-9th St. NW Wash, D.C.</i>	

RECEIVED

JUG 3 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06889
6898 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>14</u> hours		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>8417 Dixon Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CATHERINE CARTER ROCHE</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>JULY 21 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Nov. 20, 1908</u>	9. AGE last birthday: <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Joseph J. Carter</u>				14. MOTHER'S MAIDEN NAME: <u>Agnes Lyons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Frank S. Roche, 8417 Dixon Ave., Silver Spring Md.</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
433.1 Immediate cause (a) <u>Multiple Pulmonary Infarctions and Thrombosis</u>			<u>3 days</u>
Antecedent cause(s) (b) <u>Chronic Embolism, Recurrent</u>			<u>8 years</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Chronic auricular fibrillation</u>			<u>8 years</u>
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Cardiac Failure.</u>			<u>6-7 years</u>
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 10, 1955, to July 21, 1955, that I last saw the deceased alive on July 21, 1955, and that death occurred at 2:50 A.M., from the causes and on the date stated above.

SIGNATURE <u>James A. Roberts</u>	(DEGREE OR TITLE) ADDRESS <u>M.D. 8907 Georgia Ave. Silver Spring, Md</u>	DATE SIGNED <u>7/21/55</u>
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>July 23, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>7-22-55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Warner E. Pumphrey, Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 25 1955

RECEIVED

6786

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTG</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>MONTG</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR and give nearest town)	
17 TOWN <u>TAKOMA PARK</u>		17 TOWN <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00 <u>7314 WILLOW AVE</u>		<u>7314 WILLOW AVE.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>MARY OLIVIA RODGERS</u>		<u>July 8th 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>JAN 23, 1881</u>
		<u>WIDOWED</u>	9. AGE last birthday <u>74</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country): <u>PARIS, TEXAS</u>
13. FATHER'S NAME: <u>TOM CRAIG</u>		14. MOTHER'S MAIDEN NAME: <u>CRAIG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS: <u>MRS MARY ISABELLE ACREE TAK PR</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>153X PULMONARY FAILURE</u>			<u>2 DAYS</u>
ANTECEDENT CAUSE (S) (B) <u>METASTATIC CARCINOMA</u>			<u>1 YEAR</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CARCINOMA OF COLON</u>			<u>1 1/2 YEARS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1955 /</u>		19B. MAJOR FINDINGS OF OPERATION: <u>CARCINOMA OF COLON</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/24, 1955</u> , to <u>7/8, 1955</u> , that I last saw the deceased alive on <u>6/30, 1955</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James Coleman MD</u>		DATE SIGNED <u>JULY 8, 1955</u>	
M. D. <u>113 CARROLL ST NW WASH. DC</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Cremation</u>		<u>July 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cedar Hill Crematory</u>		<u>Britland Park Co., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>July 8-1955</u>		<u>254 Carroll St NW Takoma Park, MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 11 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6899

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Mainland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>6-25-55</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>7900 Linbrook Drive</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Leah</u> (Last) <u>Rosander</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>April 20, 1892</u>	
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Sweden</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>A.C. Rosander, Son, 7900 Linbrook, Bethesda, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>						<u>6 hrs.</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Heart Failure - A-V Block</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis and Enlarged Heart</u>						<u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/26, 1955</u> to <u>7/9, 1955</u> , that I last saw the deceased alive on <u>7/8, 1955</u> , and that death occurred at <u>1:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank J. Jazay, M.D.</u>				DATE SIGNED <u>7/9/55</u>			
ADDRESS <u>5707 W. Conway Ave. M.D. Chevy Chase, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-transit</u>				NAME OF CEMETERY OR CREMATORY <u>Brookside</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>				REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			
24. FUNERAL DIRECTOR <u>Samuel A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JUL 18 1955

RECEIVED

6787

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Wash DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TAKOMA PARK</u>		<u>2 mos 8 da</u>		TOWN <u>Wash DC</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & Hosp.</u>				STREET ADDRESS (If rural give location) <u>3850 Tunlaw Rd.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DAVID LEWIS SANDOE				OF DEATH: 7 3 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	MARRIED	2-8-61	94 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>WASHINGTON POST</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>PA.</u>	
13. FATHER'S NAME: <u>Anthony Sandoe</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Ceder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Laura Sandoe Same</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive Pinner aneurism</u>							<u>3 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Sanguine right leg</u>							<u>3 weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Endocarditis Glomerulonephritis</u>							<u>3 weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocarditis</u>							<u>1</u>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-25, 1955 to 7-3, 1955 that I last saw the deceased alive on 7-3, 1955, and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
SIGNATURE <u>John L. Dr. Mayo</u>				M. D. <u>5039 Kansas Ave NW</u> <u>7-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Cremation</u>				<u>7-7-55</u>		<u>Lee Crematory Washington D C</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>July 4-1955</u>				<u>John L. Dr. Mayo</u>		<u>8-4-55 - Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JUL 2 1965

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

690

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Md.		COUNTY Montg.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 119 days		CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center National Institutes of Health				STREET ADDRESS (If rural give location) 5318 Wakefield Road (Green Acres)			
3. NAME OF DECEASED: (Type or Print) Lucy Clyde Schack				4. DATE (Month) (Day) (Year) OF DEATH: July 19, 1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4 October 1906	9. AGE last birthday 48 yrs.	IF UNDER 1 YEAR Months 9 Days 15	IF UNDER 24 HRS. Hours 15 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: (First Name unknown) Clyde				14. MOTHER'S MAIDEN NAME: Ewile Morris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: The medical record, The Clinical Center		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Malignant Melanoma - multiple Metastases							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: None			19B. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from March 22, 1955 , to July 19, 1955 , that I last saw the deceased alive on July 19, 1955 , and that death occurred at 6:35A M. from the causes and on the date stated above.							
SIGNATURE Ross M. Miller			ADDRESS M.D. The Clinical Center, NIH			DATE SIGNED July 19, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-22-55		NAME OF CEMETERY OR CREMATORY Chatham Burial Park		LOCATION (City, town, or county) (State) Chatham, Virginia	
DATE REC'D BY LOCAL REGISTRAR 7-20-55		REGISTRAR'S SIGNATURE Bessie M. Thompson		FUNERAL DIRECTOR Robert H. Humphrey		ADDRESS Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06894

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Items 5,6,7, Film 184 7-28-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Mont</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> <u>TOWN Somerset</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN SOMERSET</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5419 Uppingham St.</u>		STREET ADDRESS (If rural give location) <u>5419 Uppingham St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WALTER H. SCHOELLKOPF</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>7-15-1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>OCT 11 1882</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired. <u>FOREIGN SERVICE OFFICER U.S. GOV'T</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Buffalo N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>LOUIS SCHOELLKOPF</u>		14. MOTHER'S MAIDEN NAME: <u>MYRA L. HORTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WWII #1</u>		16. SOCIAL SECURITY No.: <u>WALTER SCHOELLKOPF. WASHINGTON DC</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>(024X)</u>		(a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>Tobacco use</u> DUE TO (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Interval Between Onset And Death <u>5 years</u>	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/20</u> , 19 <u>53</u> , to <u>July 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>55</u> , and that death occurred at <u>2:15 pm</u> , from the causes and on the date stated above.			
SIGNATURE <u>Walter M. D.</u>		DATE SIGNED <u>July 15, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7.20.55</u>		REGISTRAR'S SIGNATURE <u>Bev. M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Wash. DC</u>		ADDRESS <u>os. Gawlers Sons 1756 Pa. Ave. NW</u>	

BUREAU V. 3

JUL 25 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06896

692

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Virginia</u> COUNTY <u>Nassamond</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Suffolk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>110 Parkway</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:	
(Type or Print)		<u>James Fielding SHEPHERD</u>		<u>July 27</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Aug. 28, 1896</u>	<u>58</u> yrs.	Months <u>10</u>	Days <u>29</u>	Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Credit mgmt.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Not stated</u>		11. BIRTHPLACE (State or foreign country): <u>Nebraska</u>	
13. FATHER'S NAME: <u>George Shepherd</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Bridwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>190X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Metastatic melanoma with brain stem compression</u>						<u>2/22/55</u>	
(B) <u>Metastatic melanoma</u>						<u>1948</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary metastases pneumonia, aspirations</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>2/22/55</u>		<u>Melanoma, left temporal lobe</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
<u>None</u>		<u>Home</u>		<u></u>		<u></u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>Feb. 18, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Jacob Robbins</u>		<u>M. D. Nat'l Inst. of Health</u>		<u>7/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial-transit</u>		<u>7/30/1955</u>		<u>Hollylawn</u>		<u>Nansemond Co. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8/1/55</u>		<u>Bessie M. Hontz</u>		<u>Robert A. Pumphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. 1

JUG 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06897
 6903 Item 9, Film 184 7-18-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>8618 Irvington Ave.</u>			
3. NAME OF DECEASED: (First) <u>IDA</u> (Middle) <u>M</u> (Last) <u>SHIPP</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>6</u> <u>1955</u>		5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct 20, 1879</u>		9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Patrick Willingham</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs Vivian Trapani</u> <u>8618 Irvington Ave. Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>acute congestive failure</u>						<u>20 min.</u>	
ANTECEDENT CAUSE (B) <u>Coronary heart disease</u>						<u>6 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>hypertension</u>						<u>Unk.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 May</u> , 19 <u>55</u> , to <u>6 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5 July</u> , 19 <u>55</u> , and that death occurred at <u>3:35 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. M. Thompson M.D.</u>		ADDRESS <u>7654 Georgetown Rd. Bethesda 14, Md.</u>		DATE SIGNED <u>6 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>National Mem. Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/7/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS <u>J. Wm Lee's Sons Co. 300 4th St. N.E. Wash. D.C.</u>			

RECEIVED

JUL 11 1955

BUREAU V. S.

6994

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>101 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arlington</u> <u>83 X - 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 The Clinical Center National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4861 Little Falls Road</u>			
3. NAME OF DECEASED: (First) <u>Ralph</u> (Middle) <u>Dale</u> (Last) <u>Snow</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 12</u> <u>19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 1, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Government employee</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Defense Department</u>		11. BIRTHPLACE (State or foreign country): <u>Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Ralph F. Snow</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Horracks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>199.8 Carcinoma involving the face, orbit and base of the skull with metastases to skin & lung</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
---	--

19A. DATE OF OPERATION: <u>April 21, 1955</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Extensive carcinoma of face, maxilla & nasal & oral cavities</u>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 2, 1955, to July 12, 1955, that I last saw the deceased alive on July 12, 1955, and that death occurred at 2:10 P. M, from the causes and on the date stated above.

SIGNATURE <u>Horace Herbsman</u>	ADDRESS <u>The Clinical Center National Institutes of Health</u>	DATE SIGNED <u>July 12, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7/15/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>
		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>

DATE REC'D BY LOCAL REGISTRAR <u>7-14-55</u>	REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
--	--	--	------------------------------

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06899

6905

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		76 days		TOWN <u>Alexandria</u>		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 The Clinical Center National Institutes of Health				509 N. Howard			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<u>Antonio Cornelio Sonneveldt</u>		OF DEATH: <u>July 26</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	May 18, 1917	38 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Airline Employee</u>		<u>Commerical Flying</u>		<u>Argentina</u>		<u>Argentina</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Anthony oSonneveldt</u>				<u>Metje Pruisen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		Unknown		The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
202X IMMEDIATE CAUSE (A) <u>Aspiration pneumonia</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B) <u>Malignant lymphoma</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
--		--				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		--	
--		M.		--			
22. I hereby certify that I attended the deceased from <u>May 11</u> , 19 <u>55</u> , to <u>July 26</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 26</u> , 19 <u>55</u> , and that death occurred at <u>8:05PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. Thompson Jr.</u>				ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>7-27-55</u>	
M. D. <u>Nat'l. Inst. of Health</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 29, 1955</u>		<u>Parklawn Cemetery</u>		<u>Montgomery County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/28/55</u>		<u>Bessie M. Thompson</u>		<u>Warner E. Thompson</u>		<u>Silver Spring, Md.</u>	

RECEIVED

AUG 1 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6938
CERTIFICATE OF DEATH

06900

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 107 days		CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 The Clinical Center Natl. Institutes of Health				STREET ADDRESS (If rural give location) 2544 - 17th St. N.W., Apt. 3			
3. NAME OF DECEASED: (First) (Middle) (Last) Bertha Dwan Stamatis				4. DATE (Month) (Day) (Year) OF DEATH: July 8 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: January 4, 1899	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY: --		11. BIRTHPLACE (State or foreign country): Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Ignatius Dwan				14. MOTHER'S MAIDEN NAME: Cora McIntyre			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		15. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 153X Uremia associated with pyelonephritis, left with an abscess in the left ilio-psoas muscle							
ANTECEDENT CAUSE (S) DUE TO Carcinoma of the colon metastatic to the peritoneum, lymph nodes, and to the tissue about the left ureter with obst. of the left ureter.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Multiple perforations of the bowel with adhesions. Fibrinous pericarditis, multiple petechiae, skin, heart, intestine.							
19A. DATE OF OPERATION: April 5, 1955		19B. MAJOR FINDINGS OF OPERATION: Recurrent & Metastatic cancer of colon with urinary bowel fistulae.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 23, 1955 , to July 8, 1955 , that I last saw the deceased alive on July 8, 1955 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
SIGNATURE J. Leonard Gold		ADDRESS The Clinical Center National Institutes of Health		DATE SIGNED July 9, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-11-55		NAME OF CEMETERY OR CREMATORY Boston, Mass.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 7/9/55		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Joseph Charles Long, Inc.		ADDRESS 1736 E. 4th St. N.W.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

JUL 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06901

6907

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: U.S. Naval Hospital Bethesda COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital, NNMCMC, Bethesda 14, Md.				STREET ADDRESS (If rural give location) 4624 S. Chelsea Lane			
3. NAME OF DECEASED: (First) Louise		(Middle) Wilton		(Last) STEVENS		4. DATE (Month) (Day) (Year) OF DEATH: July 16 1955	
5. SEX: Female	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 10 July 1900	9. AGE last birthday 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Washington, D.C.	
13. FATHER'S NAME: Ralph C. WILTON				14. MOTHER'S MAIDEN NAME: Amy L. FULLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Ernest E. STEVENS 4624 S. Chelsea Lane, Bethesda, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) Secondary Shock							
ANTECEDENT CAUSE (S) DUE TO (B) Abdominal + pelvic Peritonitis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Adeno Carcinoma, Cecum.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cortisone therapy + Atrophic Arthritis						3 mos. 8 days	
19A. DATE OF OPERATION: July 5, 1955		19B. MAJOR FINDINGS OF OPERATION: Adeno Carcinoma, Cecum + Fracture Femur, Rt.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 26 June, 1955 to 16 July, 1955 that I last saw the deceased alive on 16 July, 1955 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR: G. V. Russell				ADDRESS: U.S. Naval Hospital, NNMCMC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-19-55		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 7-16-55		REGISTRAR'S SIGNATURE Mary E. Casella		24. FUNERAL DIRECTOR R. A. PUMPHREY		ADDRESS 7557 Wis. Ave. Bethesda, Md.	

BUREAU V. E.

JUL 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6908

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06902

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		STATE <u>MD.</u>		COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)			
X TOWN <u>BETHESDA</u>		<u>24 YRS</u>		TOWN <u>BETHESDA</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u>				<u>4700 SOUTH CHELSEA LANE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>GEORGE HENDERSON SWEET</u>				OF DEATH: <u>JULY 24 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>AUG. 17, 1894</u>	
9. AGE last birthday: <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>WASHINGTON, D.C.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>U.S. GOVT</u>				13. KIND OF BUSINESS OR INDUSTRY:			
14. FATHER'S NAME: <u>WILLIAM SWEET</u>				15. MOTHER'S MAIDEN NAME: <u>BELLE HURLBURT</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				17. SOCIAL SECURITY NO. <u>No</u>			
18. INFORMANT & ADDRESS: <u>MRS. MAY DELANDER SWEET</u>				19. SAME ADDRESS			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>							
ANTECEDENT CAUSE (B) <u>Carcinoma of rectum.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1953</u> to <u>July 24</u> 19 <u>55</u> that I last saw the deceased alive on <u>July 24</u> 19 <u>55</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George H. Gray Jr.</u>				DATE SIGNED <u>7/24/55</u>			
23. BURIAL, CREMATION, REMOVAL, APOTHEOSIS				NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>			
DATE THEREOF <u>7/26/55</u>				LOCATION (City, town, or county) (State) <u>104 Chevy Chase Dr. Chevy Chase, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>A. H. Hines Co 2901-14 st. n.w.</u>		ADDRESS	

BUREAU V. M.

AUG 1 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6909

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06903

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>7</u> years		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>4527 Rosedale Ave. Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>4527 Rosedale Ave.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>LOUIS</u>		(Middle) <u>ELMER</u>		(Last) <u>TALBERT</u>	
4. DATE OF DEATH		(Month) <u>July</u>		(Day) <u>1</u>		(Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-5-1904</u>	9. AGE last birthday: <u>51</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Ice business Owner-Ice bus.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Warren E. Talbert</u>				14. MOTHER'S MAIDEN NAME: <u>Agnes R. Scott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>579-14-1783</u>		17. INFORMANT & ADDRESS: <u>4527 Rosedale Ave. Anna May Talbert Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Frank J. Prosch</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-1-55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u>	
DATE REC'D BY LOCAL REG. <u>7/2/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md</u>	

BUREAU V. S.

JUL 6 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06904
6910
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Bethesda</u>		<u>111</u> days		<u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>56</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>				<u>937 Bonifant St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<u>Delores Marie Thrush</u>		OF DEATH: <u>July 11</u> , 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 3, 1930</u>	<u>25</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Teacher</u>				<u>Education</u>		<u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U. S. A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joe Castello</u>				<u>Mary Mancino</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>Unknown</u>			
17. INFORMANT & ADDRESS:				<u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>600.0</u> IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>? Chronic pyelonephritis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Sarcoma with destruction of pelvic bones</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 22, 1955</u> to <u>July 11, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> , and that death occurred at <u>4:00pM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Martin Schick</u>				<u>The Clinical Center</u> <u>M. D. National Institutes of Health</u>		<u>July 12 '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/14/55</u>		<u>Mt. Olivet Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-13-55</u>		<u>Beauregard M. Thompson</u>		<u>Warner & Humphrey</u>		<u>8434 Ga. Ave.</u> <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI

JUL 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6794 Item 9, Film 185 8-30-55 et
CERTIFICATE OF DEATH

06905

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Rockville LENGTH OF STAY (in this place) 5 yrs.
TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chestnut Lodge 500 West Montgomery Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore
TOWN Baltimore 3 Vol. 4
STREET ADDRESS (If rural give location) 2701 Roslyn Ave

3. NAME OF DECEASED:

(First) Charlotte (Middle) Amelia (Last) Tickner

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1955

5. SEX:

F.

6. COLOR OR RACE:

N.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

WIDOWED

8. DATE OF BIRTH:

Aug. 30, 1868

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

87 yrs. 8 Months 7 Days 1 Hour 5 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

House wife

10b. KIND OF BUSINESS OR INDUSTRY:

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

William Bewley

14. MOTHER'S MAIDEN NAME:

Charlotte Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

9

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X
Immediate cause

(a) Leukemia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Senility

DUE TO

(c) hypertension

Interval Between Onset And Death

1 week

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension with infarct

19a. DATE OF OPERATION:

0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1942 to July 22, 1955, that I last saw the deceased

alive on July 21, 1955, and that death occurred at 5:30 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 7-25-55 Druid Ridge Pikeville, Ind.
Laurel H. Bryant Wm. Tickner & Son, Balt., Ind.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1955

BUREAU V. S.

6911

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>West Va.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>71</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairmont</u> <u>85X-3</u>			
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>50</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>516 Walnut Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mabel</u> <u>Mildred</u> <u>Toothman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 27</u> <u>19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married,</u>	8. DATE OF BIRTH: <u>October 18, 1913</u>	9. AGE last birthday <u>41</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Charles C. Parks</u>				14. MOTHER'S MAIDEN NAME: <u>Ora Wass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no 3</u>			16. SOCIAL SECURITY NO. <u>232-36-6075</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac arrest</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Malignant melanoma with widespread metastases</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>---</u> <u>2</u>		19B. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>---</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>7:15pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Schick, M.D.</u>				DATE SIGNED <u>7/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL & Removal</u>				DATE THEREOF <u>July 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>The Clinical Center</u> <u>M. D. Nat'l Inst. of Health</u>	
LOCATION (City, town, or county) (State) <u>FAIRMONT, West VA.</u>		24. FUNERAL DIRECTOR <u>Joseph Lawrence Jones</u>		ADDRESS <u>1756 Pa. Ave. NW. Wash. D.C.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7/30/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6912

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 7. Film G184 7-29-55 et Item 18 Film G184 8-9-55 and

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06907

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>California</u>	COUNTY <u>43X-3</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>7-21-55 / 7-22-55</u>	CITY (If outside corporate limits write OR and give nearest town) <u>Los Altos</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural, give location) <u>12870 Roble Ave.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Wyllie</u> (Middle) <u>B.</u> (Last) <u>Treat</u>		(Month) <u>July</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12/26/20</u>
9. AGE last birthday: <u>34</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Sanford Corp</u>	
11. BIRTHPLACE (State or foreign country): <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Sidney W. Treat</u>		14. MOTHER'S MAIDEN NAME: <u>Katharine Louisa Baird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Navy W.W.II.</u>		16. SOCIAL SECURITY No.: <u>Sidney W. Treat, Father</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
331X Immediate cause (a) <u>Extensive cerebral hemorrhage of mid brain and brain stem</u>			
DUE TO			
Antecedent cause(s) (b) <u>Marked hemorrhagic pneumonitis of both lungs</u>			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c) <u>Cause undetermined</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>James J. Burchart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-22-55</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <u>7-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>	DATE THEREOF: <u>7-22-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill</u>	LOCATION (City, town, or county) (State): <u>Suitland, Md.</u>
DATE REC'D BY LOCAL REG. <u>7-23-55</u>	REGISTRAR'S SIGNATURE <u>Rebecca M. Thompson</u>	SE. MINERAL DIRECTOR <u>Robert A. Campbell</u>	ADDRESS <u>Bethesda, Md.</u>

RECEIVED

JUL 26 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6913

06908

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>DDA</u>		TOWN <u>Gaithersburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>				STREET ADDRESS (If rural, give location) <u>Diamond Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lucy</u>				<u>July 16 1955</u>			
5. SEX: <u>Fe</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>July 27-1885</u>	
9. AGE last birthday: <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John B. Battlemay</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Alvin Trevey, Gaithersburg, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
331X Immediate cause (a) <u>Cerebral Vascular Accident</u> DUE TO Antecedent cause(s) (b) <u>Hypertension</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>1/2 hr.</u> <u>10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochert</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-16-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>7-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
DATE REC'D BY LOCAL REG. <u>July 20 5-55</u>		REGISTRAR'S SIGNATURE <u>Seamus M. Thompson</u>		24. FUNERAL DIRECTOR <u>Emmett C. Gartner</u>		ADDRESS <u>Gaithersburg Md</u>	

BUREAU V. S.

MAY 22 1955

RECEIVED

6914

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montgo.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETHESDA</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Martinsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>Dickerson, md. R.F. #2</u>	
3. NAME OF DECEASED: (Type or Print) <u>JOHN</u> (First) <u>TWYMAN</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 18</u> 19 <u>55</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>NEGR</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>3-16-1889</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>STATE ROADS</u>	
11. BIRTHPLACE (State or foreign country): <u>MONTGOMERY COUNTY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George Twyman</u>		14. MOTHER'S MAIDEN NAME: <u>David Duggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mary Twyman Dickerson, md.</u> (Granddaughter)			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>331X Cerebro-Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumo-pneumonia</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/16, 1955</u> , to <u>7/18, 1955</u> , that I last saw the deceased alive on <u>7/18</u> , 1955, and that death occurred at <u>2nd</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>Stephen C. Cromwell</u>		ADDRESS <u>M.D. Rockville, Md.</u>	
DATE SIGNED <u>7/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-23-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Warren Chapel</u>		LOCATION (City, town, or county) (State) <u>Martinsburg, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>	
24. FUNERAL DIRECTOR <u>me</u>		ADDRESS <u>Rockville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06910

6915

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (if outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda 6 days</u>	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town) <u>to Chevy Chase</u>	OR TOWN <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>73 Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>4602 Merivale Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Mary</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Walker</u>	(Month) <u>July</u> (Day) <u>7</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 24, 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. FATHER'S NAME: <u>Henry C. Browning</u>	
14. MOTHER'S MAIDEN NAME: <u>Ella Cawthorne</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Helen Lansdale Niece, 4602 Merivale Rd. Chevy Ch. Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>			<u>12 hrs.</u>
DUE TO ANTECEDENT CAUSE (B) <u>Acute Heart Failure-Dilated</u>			<u>2 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u>			<u>2 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advanced Arteriosclerosis</u>			<u>2 yrs.</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/6, 1955</u> to <u>7/7, 1955</u> , that I last saw the deceased alive on <u>7/7, 1955</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank J. Jagger Jr. M.D.</u>		ADDRESS <u>5707 Wisconsin Ave. Chevy Chase, Md.</u> DATE SIGNED <u>7/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

JUL 18 1955

BUREAU V. 2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 2 & 9: Film G184 8/8/55 dmr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06911

6916

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: <u>Kensington Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>Washington, D.C.</u>	
COUNTY: <u>Montgomery</u>	MARYLAND	STATE: <u>Maryland</u>	COUNTY: <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town): <u>X Kensington</u>	LENGTH OF STAY (In this place): <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: <u>Kensington, Md.</u>	<u>5812 Chevy Chase Parkway</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>3000 McComas Ave.</u>		STREET ADDRESS (If rural give location): <u>4109 Franklin St. N.W.</u>	<u>✓</u>
3. NAME OF DECEASED: (First) <u>Campbell</u> (Middle) <u>Easter</u> (Last) <u>Waters</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>29</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 14 - 1872</u>
9. AGE last birthday: <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>15</u>	IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chemist for U.S. Gov.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Chas. Emory Waters</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Easter</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>450.0</u> <u>Acute Congestive Myocardial Failure</u>		<u>12 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis, Generalised, Advanced</u>		<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Right Hemiplegia with aphasia, severe</u>		<u>6 wks.</u>	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>street, office bldg., etc.</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Wash. DC.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>July 29, 1955</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>July 29, 1955</u> , that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE: <u>Stewart Waff</u>		ADDRESS: <u>3921 Ingomar St. N.W.</u> DATE SIGNED: <u>July 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Cremation</u>		DATE THEREOF: <u>7-30-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State): <u>Prince George Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>8/1/55</u>		REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR: <u>Robert A. Punghe</u>		ADDRESS: <u>Bethesda, Md.</u>	

STATE OF NEW YORK

1955

BUREAU V. S.

AUG 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6917

06912
Reg. Dist. No. 214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>52 Silver Spring</u>		LENGTH OF STAY (in this place) <u>8 mo.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>56 Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3011 Medway St</u>				STREET ADDRESS (If rural, give location) <u>3011 Medway St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>William Philip Waters</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH: <u>2-22-'96</u>		9. AGE last birthday: yrs. <u>59</u> Months Days Min.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>
		10b. KIND OF BUSINESS OR INDUSTRY: <u>Auto</u>	11. BIRTHPLACE (State or foreign country): <u>Mich</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>yes</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service) <u>424-09-7654</u>		17. INFORMANT & ADDRESS: <u>Virginia Waters (wife) Home as Item 2</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>sudden death</u>
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>Frank J. Broschert</u> <u>Post Lincol. M. Examiner</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-16-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>7-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTING TON CEM.</u>		LOCATION (City, town, County, State) <u>BALTING TON MD</u>	
DATE REC'D BY LOCAL REG. <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>THE S. H. HINES CO.</u> <u>1901-14th ST. N.W. WASH. D. C.</u>			

BUREAU V. S.

JUL 20 1955

RECEIVED

6788

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park LENGTH OF STAY (in this place) 17 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Wash. Sanitarium Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 56 Silver Spring
 STREET ADDRESS (If rural give location) 544 Beacon Rd.

3. NAME OF DECEASED:

(First) Mabel (Middle) Alice (Last) Welles

4. DATE (Month) (Day) (Year)
 OF DEATH: 7-4-1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH:

9. AGE last birthday 69 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Wm. Schnurr

14. MOTHER'S MAIDEN NAME:

Hannah Hubley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT & ADDRESS:

Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Encephalo-Pneumonia

General Nervousness

(B) Generalized Osteomyelitis

(C) Extremities Neck

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1955 to July 4, 1955, that I last saw the deceased alive on July 3, 1955, and that death occurred at 215 E. M. D. 501-12 from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 4 1955J. William LaddThe S.H. Hines Co. 2901-14th Ave. N.W. Washington D.C.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

1955

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

JUL 2 1955

RECEIVED

6918

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE		COUNTY <i>47X-3</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Clarksburg</i>		LENGTH OF STAY (in this place) <i>5 days</i>		TOWN <i>Washington, D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>4336 Southern Ave. S.E.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>SARAH GRACE CECELIA WELSH</i>				<i>7 - 12 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	Months	Days	Hours
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>6-20-1891</i>	<i>64</i>			
10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife in own home</i>				<i>Washington, D.C.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Wilbur Kiplinger</i>				<i>Margaret Shugrue</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>none</i>		<i>Margaret Riedel Clarksburg Md</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>602x</i>							
Immediate cause							
(a) <i>Arteriosclerotic cardiovascular disease</i>							
DUE TO							
Antecedent cause(s)							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
(b) <i>Renal calculi</i>							
DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/12</i> , 19 <i>55</i> , to <i>7/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/12</i> , 19 <i>55</i> , and that death occurred at <i>10:30 p.m.</i> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>James P. Kerr M.D.</i>				<i>7/12/55</i>			
ADDRESS							
<i>Damascus, Md.</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>8-15-1955</i>		<i>Bedar Hill Cemetery</i>		<i>Southeast, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>July 13, 1955</i>		<i>Della W. Burdette</i>		<i>Walley's Funeral Home</i>		<i>3200-R. 8 Ave. Mt. Rainier, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6915

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY <u>Montg. Co. 15X-1</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	LENGTH OF STAY (in this place) <u>4 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 16</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5266 - River Rd.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Malochi</u>	(Middle) <u>William</u>	(Last) <u>Williams</u>	DATE OF DEATH: <u>July 4</u> 19 <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married Feb. 2, 1883</u>	8. DATE OF BIRTH: <u>Feb. 2, 1883</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: <u>Emma Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <u>Mrs. Mary Williams 5266 - River Rd. Wash. 16 D.C.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Encephalomalacia, & infection</u>			<u>1 wk ?</u>
ANTECEDENT CAUSE (S) (B) <u>Rt. cerebral hemisphere</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Thrombosis, Rt middle cerebral artery</u>			<u>1 wk ?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 July 1955</u> , to <u>4 July 1955</u> , that I last saw the deceased alive on <u>4 July</u> , 19 <u>55</u> and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Stephen C. Cromwell</u>		ADDRESS <u>N. D. - Rockville, Md.</u>	
DATE SIGNED <u>7/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>7/7/55 Wood Lawn C</u>		DATE THEREOF <u>7/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Wood Lawn C</u>		LOCATION (City, town, or county) <u>D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>W. H. Thompson</u>	
24. FUNERAL DIRECTOR <u>William J. M. Hester</u>		ADDRESS <u>2218 1/2</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 8 1955

RECEIVED

6920

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Olney</u>		<u>5 days</u>		<u>Rockville</u> <u>26</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Montgomery County General Hospital, Inc.</u>				<u>10 Williams St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Walter Anderson Williams</u>				<u>July 13 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>1/19/1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Government employee (District)</u>			<u>Maryland</u>	<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Richard M. Williams</u>				<u>Rose Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
2040 IMMEDIATE CAUSE (A) <u>Acute lymphatic leukemia</u>						<u>Few weeks</u>	
ANTECEDENT CAUSE (S) (B) <u>Terminal right hemiplegia</u>						<u>4 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Bronchopneumonia, congestive</u>						<u>4 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>None</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1830</u> , 19 <u>55</u> , to <u>7/13/55</u> 19 <u>55</u> , that I last saw the deceased alive on <u>7/12/55</u> , 19 <u>55</u> , and that death occurred at <u>6:50aM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>W. B. Finkbeiner</u>		<u>Rockville, Md.</u>		<u>7/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-15-55</u>		<u>Rockville Union</u>		<u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-13-55</u>		<u>Gertrude B. Lawler</u>		<u>Robert A. Runyphay</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 3

JUL 18 1955

RECEIVED

6789

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>District of Columbia</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
17 TOWN <i>Takoma Park</i>		17 days		21 Washington, D.C. 478-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <i>Washington Sanatorium Hosp.</i>				538 Peabody St. N.W.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <i>Harriet Hulda Williamson</i>				OF DEATH: <i>7/26 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F</i>	<i>White</i>	<i>Widow</i>	<i>2/2/75</i>	<i>80</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Housewife</i>						<i>Canada</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Frederick Lutton</i>				<i>Catherine Jaspet</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>Y</i>						<i>Hospital Record</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE						<i>5 days</i>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<i>1 week</i>	
(A) <i>Bronchopneumonia</i>							
(B) <i>Congestive Heart Failure</i>							
(C) <i>Arteriosclerotic Heart Disease</i>						<i>4 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 3, 1955</i> , to <i>July 26, 1955</i> , that I last saw the deceased alive on <i>July 26, 1955</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>H. Orleans & H.T. Morn</i>		<i>7800 Carroll Ave - Takoma Park</i>		<i>7/26/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7-29-55</i>		<i>Congressional Cem.</i>		<i>Washington D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>July 26 1955</i>		<i>J. Nelson Dodels</i>		<i>Local Funeral Home</i>		<i>4812 Johnson St. Wash D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 28 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6921

06918

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Mt Airy - RFD #3</u>		LENGTH OF STAY (in this place) <u>1 1/2 hr</u>		TOWN <u>Damascus</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brown Church R</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Robert</u>		(Middle) <u>Leo</u>		(Last) <u>Windsor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 1 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 15, 1922</u>		9. AGE last birthday: <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter - Army</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Medical Center</u>		11. BIRTHPLACE (State or foreign country): <u>Ridgeville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert I. Windsor</u>				14. MOTHER'S MAIDEN NAME: <u>Lucinda Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY No.: <u>577-24-0667</u>		17. INFORMANT & ADDRESS: <u>Mrs Robert L. Windsor, Damascus, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>seconds</u>
929.8 Immediate cause (a) <u>Asphyxia</u> DUE TO							
Antecedent cause(s) (b) <u>drowning</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>7-1-55</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>farm pond</u>		21c. (City or town) (County) (State) <u>Mt Airy RFD #3 Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-1-55 8 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>drowned while swimming</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschaut</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Damascus</u>		LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
DATE REC'D BY LOCAL REG. <u>7/3/55</u>		REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>		24. FUNERAL DIRECTOR <u>Olin L. Molesworth</u>		ADDRESS <u>Damascus, Md.</u>	

RECEIVED

JUL 6 1955

BUREAU V. 2

6795

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Rockville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

12916 Ardennes Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Rockville

STREET ADDRESS (If rural, give location)

12916 Ardennes Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HELENEMARIEWOLF

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

July 4, 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Female

White

Widowed

May 27, 1880

75

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Own Home

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

J. Hinrich Johansen

14. MOTHER'S MAIDEN NAME:

Ilse Dres

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

4

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs Wilbur R. Gordon-Item# 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

157X

Immediate cause

(a)

DUE TO

Generalized Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 mos.

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

Carcinoma, head of pancreas1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955, to 4 July 1955, that I last saw the deceased alive on 4 July, 1955, and that death occurred at 6:20 p.m., from the causes and on the date stated above.SIGNATURE 36 June 55

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

W. H. HallM.D.Rockville, Md.7/4/55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial-Transit

7-5-55Nutley, N.J.Nutley, N.J.DATE REC'D BY LOCAL REG. 7/11/55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Laurel St. GraysonRobert M. CampbellBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

JUL 13 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6922

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	STATE <u>D.C.</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington 47X-3</u>
TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>14 days</u>		STREET ADDRESS (If rural give location) <u>3018 TERNISON ST. NW</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY FRANCES Wolfe</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 16 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 26, 1892</u>
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Switchboard operator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Massachusetts</u>	
11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Campbell</u>		14. MOTHER'S MAIDEN NAME: <u>MARY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>g</u>		16. SOCIAL SECURITY No. <u>9</u>	
17. INFORMANT & ADDRESS: <u>Fred W. Winkelmann, Nephew</u>		3018 TERNISON ST. NW WASH. D.C.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>157X</u>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(A) <u>Adenocarcinoma Metastatic Large</u>		
DUE TO <u>primaries lymph nodes, pericardial sac, pleura, bilateral</u>		
(B) <u>Adenocarcinoma, Head of Pancreas</u>		
DATE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/30, 1955, to 7/16, 1955, that I last saw the deceased alive on 6/14, 1955, and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE <u>John B. Umborn</u>	ADDRESS <u>M. D. 8805 Conn. Ave. N.W. Wash. D.C.</u>	DATE SIGNED <u>7/16/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-18-55</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>
LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	24. FUNERAL DIRECTOR <u>S.H. Harris Co</u>	ADDRESS <u>2901 14th St. N.W.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-16-55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06921

Reg. Dist. No. 223-

Item 9. Film G185 8-16-55 et

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME OF DECEASED) STATE <u>MARYLAND</u> <u>PRINCE GEORGES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>17 Hudson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>College Park, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Takoma Park, Md</u>		STREET ADDRESS <u>8907 Falls Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>NELLIE ONTHANK WOOSTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 3 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 21, 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chas H. Onthank</u>		14. MOTHER'S MAIDEN NAME <u>Helen McDonald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>N.W. Wooster 1402 S. Lanoka</u>		<u>Hyattsville</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause <u>Chronic Congestive Heart Failure</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(a) <u>Broncho pneumonia</u>			
(b) <u>Generalized Atherosclerosis</u>			
(c) <u>---</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Neither</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2, 1955</u> to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>9:05</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Ed. F. Fierman M.D.</u>		DATE SIGNED <u>7/3/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) (State) <u>College Park, Md</u>	
DATE REC'D BY LOCAL REG. <u>July 4, 1955</u>		24. FUNERAL DIRECTOR <u>F. G. Sosa</u>	
REGISTERAR'S SIGNATURE <u>J. H. Johnson</u>		ADDRESS <u>1402 S. Lanoka Hyattsville, Md</u>	

RECEIVED

JUL 8 1955

BUREAU V. S.

6922

CERTIFICATE OF DEATH

Reg. Dist. No. 214

I. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING, MD. LENGTH OF STAY (in this place) 40 yrs.
 TOWN SILVER SPRING, MD.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 9218 MANCHESTER ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. OR TOWN 56
 STREET ADDRESS (If rural, give location) 9218 Manchester Road

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

NORAELIUSWRENN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JULY 161955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWWIDOWEDAugust 6, 187450 yrs.11MonthsDaysHoursMin.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

HousewifeOwn homeNorth CarolinaU.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Wm. Henry EllisFrancesFarrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoNoneMrs. Margaret W. Neumann

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) DUE TO

cerebral Thrombosis10 Hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

cerebral Atherosclerosis12 years

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Rheumatoid arthritis and Heart Failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9, 1955, to July 16, 1955, that I last saw the deceased alive on July 16, 1955, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James A. RobertsM.D.8907 Georgia Ave. Silver Spring, Md.July 16, 1955

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-18-55Frances PotterWarner E. Humphrey8434 Ga. Ave.Silver Spring, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. 3

JUL 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06923

6924

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 2 1/4 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pineview Rest Home		STREET ADDRESS (If rural give location) 5509 McKinley Street	
3. NAME OF DECEASED: (First) (Middle) (Last) William M. YOUNG		4. DATE (Month) (Day) (Year) OF DEATH: July 23 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: April 20, 1892
9. AGE last birthday: 63 yrs.		IF UNDER 1 YEAR: Months 3 Days 3	IF UNDER 24 HRS.: Hours 3 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life) Paymaster Retired		10B. KIND OF BUSINESS OR INDUSTRY: Wash. Sub. San. Com.	11. BIRTHPLACE (State or foreign country): Montgomery Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Robert Lee Young	
14. MOTHER'S MAIDEN NAME: Lucy Anna Wade		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Mrs. E. W. Wettengel-Same Item #2	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) myocardial failure			30 min
ANTECEDENT CAUSE (B) Coronary arteriosclerosis			5 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes Mellitus			15 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1952 to July 23 1955 , that I last saw the deceased alive on July 22, 1955 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
SIGNATURE Stephen R. Jones		DATE SIGNED 7/23/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/26/1955	
NAME OF CEMETERY OR CREMATORY Monocacy		LOCATION (City, town, or county) (State) Beallsville Maryland	
DATE REC'D BY LOCAL REGISTRAR 7-23-55		REGISTRAR'S SIGNATURE Bea M. Thompson	
24. FUNERAL DIRECTOR Robert A. Humphrey		ADDRESS Bethesda, Md.	

BUREAU V. S.

JUL 26 1955

RECEIVED